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proceedings:

Psychiatric Mental Health Nursing Recruitment to the Specialty

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PROCEEDINGS

PSYCHIATRIC MENTAL HEALTH NURSING: RECRUITMENT TO THE SPECIALTY

Philadelphia, Pennsylvania

April 30-May 1, 1981

Sponsored by

The University of Pennsylvania
School of Nursing

In Cooperation with

The Psychiatric Nursing Education Branch
Division of Manpower and Training
National Institute of Mental Health

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PREFACE

The School of Nursing at the University of Pennsylvania hosted a two-day conference on April 30 and May 1, 1981 focusing on the topic "Psychiatric Mental Health Nursing: Recruitment to the Specialty."

The development of such a conference grew out of increasing concern in service and education over declining interest of nurses in entering the mental health arena. Since the number of nurses in this field has always been painfully small, the decline in interest in the past few years clearly had to be addressed. With a grant award from the Psychiatric Nursing Education Branch of the National Institute of Mental Health to the University of Pennsylvania School of Nursing, the Planning Committee brought together representatives from nursing education and service, state and national mental health officers, and others to address the issues and develop a set of recommendations which can be used as planning guides for national, state and local education and service agencies.

The invitational conference was attended by a total of 51 participants. These included representatives of 20 different nursing schools from all regions of the country, participants from federal, state and private agencies and institutions, and two national professional organizations of nurses.

Opening remarks were made by Dr. Claire M. Fagin, Dean of the School of Nursing at the University of Pennsylvania, papers were presented by Dr. Herbert Pardes, Director, and Dr. Rhetaugh Dumas, Deputy Director, of the National Institute of Mental Health, and reports on recruitment problems and issues were given by other participants. Preliminary data from a national survey on the clinical and educational interests of nurses were reported in three separate presentations.

Small group sessions focused on issues related to marketing strategies, undergraduate curriculum issues, shortage consequences in the service settings, the value of master's level nurses to the mental health field, and minority recruitment. Participants chose a small group of interest to them.

Each small group leader opened the session with a paper outlining the issues. Participants were encouraged to supplement the leader's remarks with brief presentations of the issues from their own vantage point in the mental health system. The task of each group was to discuss the issues and formulate a set of recommendations for consideration by the assembly in its closing strategies session.

The final hours of the workshop were devoted to the presentation and consideration of the recommendations of each small group. This session also included discussion of strategies for implementation of the workshop recommendations.

For the most part, the papers are reproduced here essentially as presented at the conference. However, in preparing this report for publication, some minor revisions have been made. These include numbering of all tables and charts and referring to them by number in the text and editing of the text in certain instances.

While the papers included here cannot bring to the reader the depth or intensity of discussion which was generated at the conference, the Proceedings do provide a perspective on the issues of recruitment to psychiatric mental health nursing and they outline the policy recommendations of this assembly for affecting change.

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OVERVIEW OF NATIONAL MENTAL HEALTH ISSUES

Herbert Pardes, M.D.

I am delighted to be here. Since we are a small enough group to be relatively informal, I would like to make use of this opportunity for an open exchange with you. But, first, let me comment briefly on developments in three areas:

- I would like to give you a sense of what we see as major developments and advances in mental health broadly in recent years.
- Second, I will describe the current situation as regards Federal policy and budget plans for mental health.
- Lastly, I will comment on our hopes for this conference.

Over the past 30 years, the mental health field has witnessed as many and as dramatic a series of changes as any component of the health care system. The import of these changes may be appreciated more clearly if one has a sense of the dimensions of mental health problems in the country. Impressive advances in mental health epidemiology in recent years have yielded increasingly solid data on the nature and extent of mental disorder in the population. The data now indicates that 15 to 20 percent of the population experience a diagnosable mental disorder during the course of a given year. Even if one uses the more conservative percentage, that means approximately 33 million people annually suffer from mental disorders. The financial cost is estimated at $20 million in direct clinical care and an additional $20 million in indirect costs, that is, costs associated with death, disability, and loss of productivity.

Clearly, mental disorders represent one of the most severe public health problems that the Nation confronts. While the magnitude of the problem is considerable, significant progress has been made in each of the three areas--research, services, and personnel training--for which NIMH traditionally has assumed national responsibility and leadership.

With respect to services, a system that formerly was oriented predominantly to long-term institutional care now places primary emphasis on outpatient service programs. In 1955, there were 1.7 million episodes of care in mental health facilities in the U.S. In 1975, there were 6.9 million episodes of care. During that time, the settings in which patients received care reversed in quite a dramatic fashion: in 1955, approximately 77 percent of people receiving mental health services did so as inpatients; by 1975, that pattern had reversed, with 76 percent of patients receiving outpatient mental health services, and only 24 percent treated as inpatients.

Now the pros and cons of that trend reflect a number of complex issues on which I will not comment at this time. I do feel that one can argue that community-based care ideally is more humane, more appropriate, and more effective than long-term institutional care for many people with mental illness, but for a variety of economic and societal reasons, community care has never attained a fully adequate level of support. Nonetheless, you should be aware of the rather striking change in the delivery system.

The mental health system also has been one which has pioneered the concept of interdisciplinary efforts. The use of teams, comprised primarily of the core mental health disciplines, but also drawing on the talents and contributions of other professions and individuals, has been characteristic of mental health for many years and has influenced other areas of the health care system broadly.

Equally significant and far reaching changes have been occurring within the recent past several years. We have moved from a primary concern with community mental health centers to a focus on the nature of the overall mental health system. Our intent is to bring the system together more effectively and that theme, I think, is apparent both in the nature of the block grant that has been recommended and previously, in the Mental Health Systems Act that was passed in late 1980. Now I will come back to these legislative actions and proposals in a moment, but let me summarize the trends I have referred to by saying that we have a rather diversified service system which has changed dramatically over the past two to three decades. Today, it is a service system characterized by substantial interdisciplinary interaction and a concern about tightening up the system to make it function as efficiently, effectively, and appropriately, in terms of individual's needs, as is possible.

With regard to our research activities, there are few other fields in medicine or health that can rival the excitement one senses currently in mental health. Advances in basic and clinical research offer the potential for extraordinary possibilities for the future. One of the most dynamic areas is neuroscience. The identification of specific receptor sites in the brain that are responsive to specific chemical agents; the discovery of naturally occurring substances that apparently have a direct effect on mood and behavior; the development of the PETT scanner, and its application to mental health research and even clinical work--these are all ongoing areas of research that have opened up just within the past few years.

With regard to the PETT scanner, for example, we are seeing already clinical applications in the ability it offers physicians to see precise areas of the brain that are correlated with certain conditions such as epilepsy. Unlike the CAT scanner, which offers the ability to look into brain structure, the PETT technique allows us to look at function. Already, some differential functions can be viewed as they correlate with different treatments. The next question, then, is what kinds of treatment will result in modification of specific psychopathological conditions, such as the hallucinations characteristic of schizophrenia. An even more recent application of the PETT scanner now underway at NIMH is focusing on protein synthesis within the brain; this work promises the possibility of seeing brain function or deterioration associated with different conditions or phases of life.

Another major breakthrough has been the recent successful transplant of brain tissue from one animal to another. In this work, fetal brain tissue, grafted to the brain of a second animal, corrected an induced motor disorder that mimicked symptoms of Parkinson's disease. In a subsequent study, the researchers have demonstrated a successful auto-transplant within a given animal, placing tissue from the adrenal gland into the brain where the necessary circuitry develops to replace damaged brain function. Though this is now very basic research, the possibilities are impressive; in the future we may be able to address in a direct fashion diseases which involve brain structure deterioration.

In areas other than the neurosciences, we also are seeing some promising advances. A number of developmental scientists, in this country and abroad, are pursuing lines of study, with high risk children, for example, that greatly increase the likelihood of early detection and prevention of certain disorders.

In the area of therapeutics, we are seeing an increasingly broader spectrum of psychopharmacological agents, a remarkable diversification in types of psychotherapy, and a number of studies demonstrating the positive interactive effects of combined therapeutic approaches. Just let me offer one specific example. In the treatment of manic depressive illness, lithium appears to help about 70 percent of the patient population. NIMH investigators recently tested the usefulness of carbamazepine, a drug used with certain neurological conditions, among a small group of patients who have not responded to lithium. The drug appeared to have benefitted a substantial number of this population of non-responders to lithium. Thus, an increased number of depressed patients for whom no effective treatment existed only a short while ago, now would appear to have access to appropriate treatment for the disorder.

I could go on, but I just want to emphasize that the opportunities in mental health research are extraordinary. And there is another point I should emphasize: that is, that we are concerned that the nursing profession is represented inadequately both in the conduct of, and in participation with, mental health research. According to our Institute records, nurses have submitted only some 28 research applications to NIMH over the past five years. Of related concern is the difficulty we experience in identifying nurse researchers who can serve on our research review committees. We believe that nursing has a role to play in mental health research and research policy guidance, but that role is not being realized. I think perhaps this is one of the issues that would be appropriate for your discussions at this conference.

Let me comment, in a bit more detail, on issues pertaining to clinical training. Since 1948, NIMH has supported training in all of the core professions. Dr. Fagin noted, in her fine article on shortages in nursing, that NIMH support of mental health nurse training marked the initial involvement of the Federal Government in nurse training broadly. What has been the result of our participation? A 1978 report of the ADAMHA Personnel Policy Analysis Task Force estimated that in 1947, fewer than 20 mental health nurses held master's degrees or doctorates in nursing. Since that time, NIMH support has provided for nearly 20,000 traineeships in nursing. According to the Task Force report, a recent ANA survey of members identified 54,000 nurses working in mental health positions, more than 6,000 of whom held master's degrees or higher.

In the late 1970's, the NIMH decided to redirect, across the board, its clinical training programs to provide needed support for areas that were particularly underserved. Our emphases were training programs responsive to the specific needs of chronically mentally ill patients, children, and the elderly; programs that focused on the relationship between health and mental health; and programs in which participants would agree to focus efforts on the provision of services to individuals in geographically underserved areas. I gather that Dr. Chamberlain and Mrs. Marshall, the administrators of the NIMH nursing education program, will talk a bit more about the impact of the redirection on the programs the Institute supports. I would just point out that the overall redirection is consistent with our intent to provide mental health services to the traditionally unserved or underserved population groups.

On the subject of training, I would call to your attention another particular need of which we are aware. A moment ago, I mentioned the shortage of nurses in research; in the broader context, there is growing concern about the inadequate numbers of clinical researchers in all areas of health and mental health. The NIMH has employed a number of strategies to stimulate the interest of professionals in clinical research training, and we are placing special emphasis on the need for minorities in this area. Within the past couple of years, we have established within ADAMHA a Minority Access to Research Careers, or MARC, program, and we are participating in the Minority Biomedical Support Program at the NIH. The role and contributions of nurses in clinical investigations is another issue I would hope you consider.

Now to ensure that we have time for an exchange among ourselves, let me describe briefly what is happening in terms of the budget, and then suggest a few additional thoughts for the conference.

As you are aware, there has been within recent years, a massive re-examination of the Federal role as it affects literally every program operating out of Washington. Both the Congress and the Administration have shown increasing responsiveness to the country's call for a greater degree of fiscal conservatism. What do these developments mean for mental health? Earlier, I said I would return to some of the legislative issues. I will do that in the context of budgetary concerns.

With regard to a large number of Federal programs, including mental health services, the Administration policy is to incorporate mental health services within a larger health services block grant. The philosophy underlying the block grant proposal is that States and local policy bodies are in the best position to determine State and local needs and to tailor programs to those particular needs. In many ways, this thinking parallels the thinking that resulted in the Mental Health Systems Act last year. That Act was a significant step toward bringing the States into a more active position in the operation of and responsibility for federally supported mental health programs. The major difference is that the Systems Act would have been an intermediate step; the block grants will shift the responsibility and the function much more directly and immediately.

Another feature of the block grant that makes it attractive to State and local legislatures and administrators is its simplicity. The regulations will likely cover little more than the need for a certain percentage of funds--approximately 93 percent--to be retained within the area for which the block grant was designed, and some requirement for State audits. This is in contrast to the enormous burden of detailed regulations and reporting requirements that have grown up with Federal categorical programs. Implementation of the block grant will eliminate, essentially, the Federal role in direct support of mental health services.

In research, the President's budget calls for a continued NIMH national leadership role. The Institute will continue to operate its rather extensive intramural programs, and we will continue to support extramural research. The one important qualifier on the research agenda is the planned phasing down of general social research and concurrent re-emphasis on the major mental health clinical problems, as well as the biological and behavioral substrates of mental illness and health.

With respect to clinical training, the Administration is recommending continuation of Federal support only for the next year and one-half. Under the proposal we will honor continuation awards until the end of fiscal year 1982; as of February, we have stopped funding new grants. The Congress, to this point, seems to be opposed to such a phaseout of clinical training.

In research training, recommendations call for continued support of students, fellows, etc., but elimination of institutional support and overhead costs that in the past have been written into research training grants. Again, however, the Congress appears to want institutional support and overhead costs continued. Also, as proposed for research, general social research training would be phased down substantially.

We won't have final action on these proposals until later this summer. I do think we have to recognize, however, and there is broad agreement on this, that we have a major problem with the economy of this country. Correction of the problem requires dramatic and strong actions, and this Administration is ready for the job. These developments, and the overall situation, add to the urgency and importance of this conference. So let me turn to our interests and expectations for the next couple of days.

All of us are in the rather interesting position of discussing issues in mental health or, more specifically, issues critical to psychiatric nursing's future, in the face of a Federal decision to phase out support of clinical training. But I am convinced that the decision does not lessen the importance of the conference. There are many ways in which to address clinical training needs; direct Federal support is not the only answer. It is clear that nursing is an essential contributor to all aspects of mental health. Similarly, the issues that have been identified as problems--recruitment, retention, educational criteria--cut across the spectrum of health settings. How does one get people to attend to the question of appropriate salaries, appropriate perquisites within jobs, appropriate respect for the role of nursing on the health team? These are questions that should involve all segments of the society who are concerned about our Nation's health service delivery system. We at the NIMH have been concerned about a similar set of problems affecting psychiatry, and last year helped to organize a conference, much like this one, for the profession of psychiatry. A number of recommendations were issued by conference participants, and they did require response from society broadly. I hope that we will see something of the same order come out of this meeting. The Federal Government's attitude will be to remain as helpful and responsive as possible within the constraints that are on us. To encourage you to move toward a broad consideration of the issues and needs, I would suggest a number of questions you might address:

What is the distinction between problems in psychiatric nursing in contrast to problems of nursing in general? Are they the same? Are they different? What are the specific issues that you see as peculiar to this particular area of nursing? What is the number of master's level nurses in mental health? It is essential that we get as firm data as might be possible. In many of the discussions we've had with people who are out of the mental health field, who are out of Washington, the better, the harder our data, the more solid our rationale, the better we do. What are the current roles for mental health nurses? Are those the roles that are desired by the profession? Should there be alternatives? What is the amount of mental health training in the curriculum? Have there been any changes in that in the past few years? Is it sufficient? Is it the kind of curriculum that you think it should be? Are there adequate numbers of minority students coming into nursing? If not, why not? How do we encourage larger numbers of minority students to come into mental health nursing? What inducements might be necessary? What questions here might be related to the question of the overall reimbursement system which I think plays a tremendous role in relation to many of these general manpower resource issues?

Understanding the situation that the NIMH is in, what recommendations would you make to us, even within a constrained and rather tight authority in terms of what we can do? What kinds of advice or what kinds of recommendations would you like to make to us?

I'd like to say that we appreciate your coming here and participating and helping in this problem. It seems to me that in mental health, frequently there are a number of people who lament the problems, but stay in their own back yard and do nothing about them. I always appreciate those of you who are willing to take time from your other responsibilities to come and give of your time for the broader questions that are important not only to the profession itself, but also to the Nation's health care system. I hope you can realize that our presence here is a sign of our concern and our interest in helping. Again, I would like to emphasize that this is a difficult situation, but to the extent that we can, we would like to help and I hope you will give your best towards helping us.

Thank you.

RECRUITMENT PROBLEMS FROM THE PSYCHIATRIC NURSING EDUCATION BRANCH PERSPECTIVE

Jeanette Chamberlain, R.N., Ed.D., F.A.A.N.
Shallie Marshall, R.N., M.S.N., M.P.H.

Dr. Chamberlain and I have developed several tables and graphs depicting some of the problems of recruitment into psychiatric-mental health nursing. There has been a decline in the percentage of enrollments in this specialty compared with other nursing specialties. The budget allocations to the Psychiatric Nursing Education Branch have been dramatically reduced over time, compounded by problems of inflation and increasing cost of tuition and fees. Another major problem in recruitment relates to the limited number of minority students and educators in the psychiatric-mental health field. We will present these issues graphically for your consideration during the proceedings of this conference.

Figure 1 shows the full-time enrollments of nurses in advanced clinical practice graduate programs by nursing content area from 1968 to 1978. In 1968 more than 40 percent of enrollees were in psychiatric nursing. In 1978 less than 18 percent of the enrollees had selected psychiatric nursing.

Figure 2 shows that most master's prepared nurses during the two-year period, 1976-78, chose the "Other" category (which includes nurse practitioners) and medical-surgical nursing as their content area. There was a 3.5 percent increase in the medical-surgical graduates and a .6 percent decrease in psychiatric-mental health nursing graduates.

Figure 3 shows minority undergraduate and graduate nursing students enrolled in a sample of twenty-eight schools across the country. Minority categories are designated by H-Hispanic, AI-American Indian, A-Asian, B-Black, and W-White. The combined total of all minorities equals approximately 10 percent of the students.

These data were collected by the staff of the Psychiatric Nursing Educatión Branch, NIMH, during site visits made to universities in 1978. Most of the schools reported severe difficulty in recruiting and retaining minority students at both educational levels. The data show that the limited undergraduate enrollment will perpetuate the problem of having a small pool of baccalaureate graduates from which to draw for master's degree programs in psychiatric-mental health nursing.

Figure 4 indicates the critical shortage of minority faculty. The total number of full-time minority faculty in 29 nursing schools represented only 5.7 percent of the total faculty. These data were collected during Psychiatric Nursing Education Branch site visits to Schools of Nursing, at which time nursing school administrators were reporting severe difficulty in recruiting qualified minority faculty due to the extremely limited pool of candidates. Also, nursing program administrators believed that lack of minority faculty affected recruitment and retention of minority students due to the lack of role models for them.

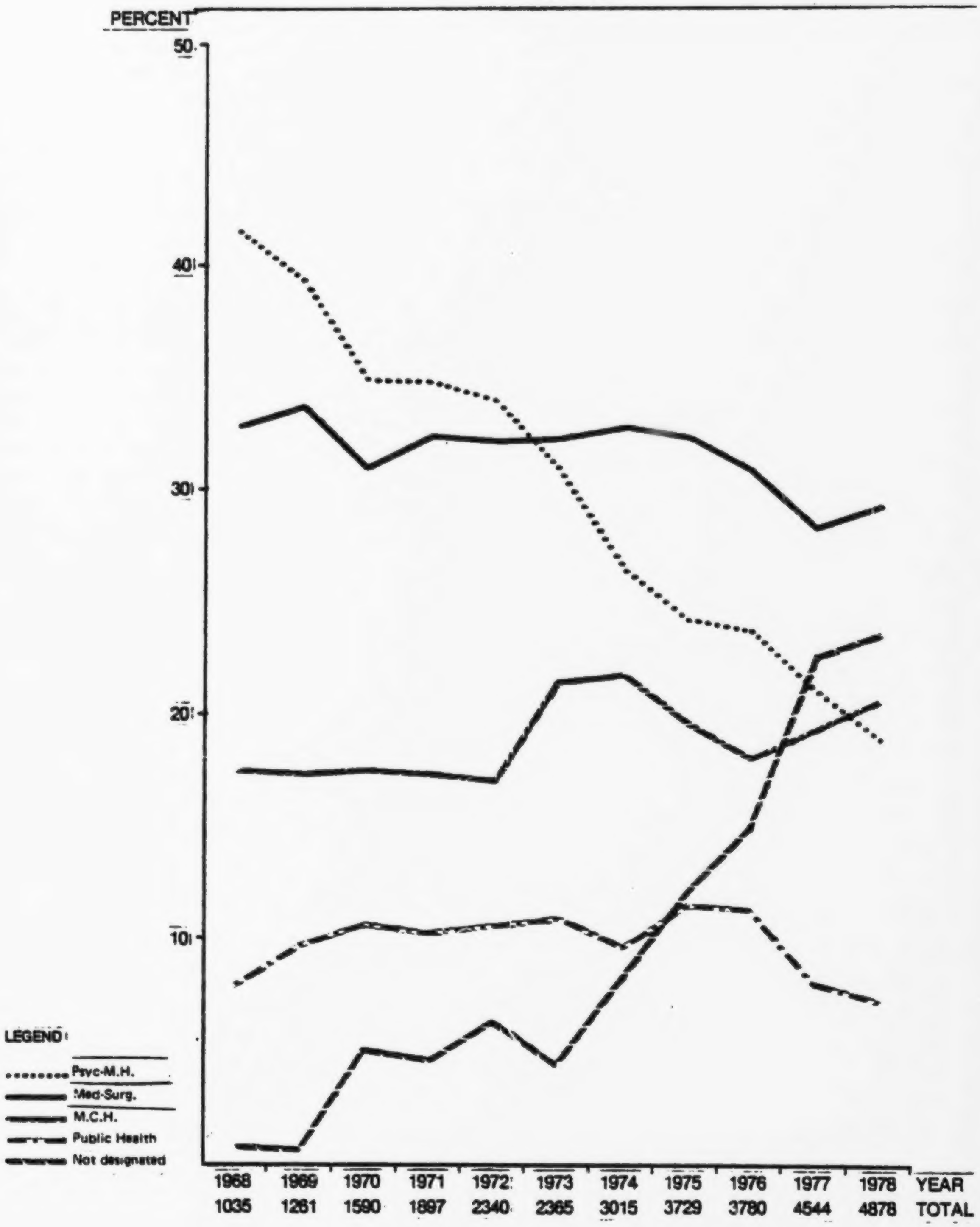
Figure 5 shows the costs of Psychiatric Nursing Education Branch (PNEB) supported programs over a five-year period. The average total program cost increased by $24,000 between fiscal years 1976 and 1980. As trainee and teaching costs escalated, the total number of PNEB supported programs decreased because budget allocations remained at about the same level. Factors contributing to program costs were inflation (which affected salaries and other teaching costs), increase in tuition and fees, and an increase in the annual stipend rate from $3,900 to $5,040. Presented with the dilemma of limited PNEB funds, program directors overwhelmingly preferred to support traineeships rather than teaching costs. In spite of the preservation of traineeships, actual numbers of master's level trainees supported decreased from 1,252 in 1976 to 797 in 1980. The future will show the impact of this funding problem on the availability of qualified psychiatric-mental health nurses to provide high quality services to clients.

Figure 6 shows that the budget of the Psychiatric Nursing Education Branch declined over the past eleven years, from a total of $10.6 million in 1970 to $7.2 million in 1981. (The impoundment of Federal funds in 1973 and their release in 1974 accounted for the relatively small budget in 1973 and the larger one in 1974.) The decrease in the number of annual stipends awarded reflects these budget changes--total stipends declining from 1,377 in 1970 to 784 in 1981.

FIGURE 1

FULL-TIME ENROLLMENTS OF NURSES IN MASTER'S PROGRAMS PREPARING FOR ADVANCED CLINICAL PRACTICE, BY NURSING CONTENT AREA

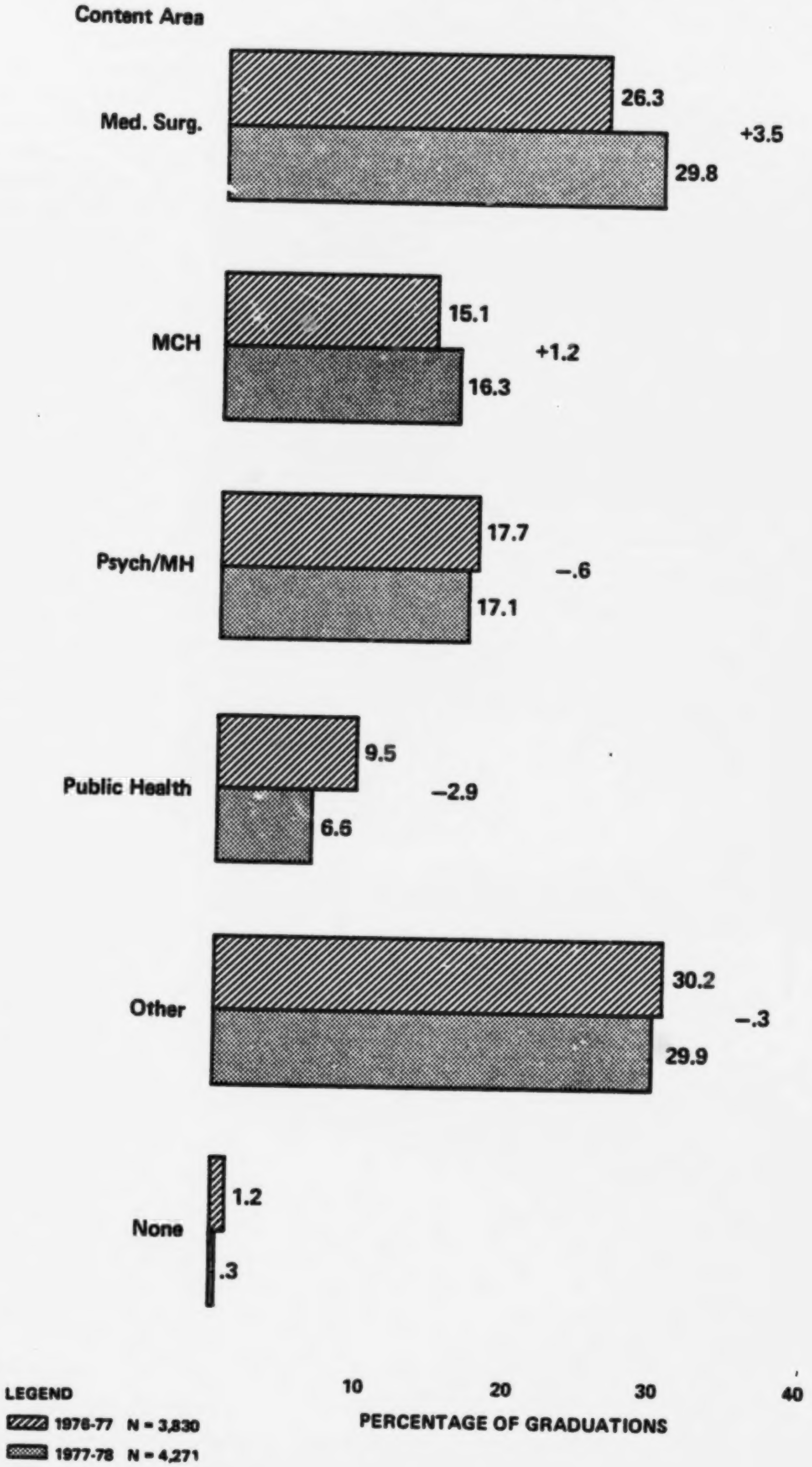
1968-1978



NLN Nursing Data Book (Pub. #19-1797, p. 63)

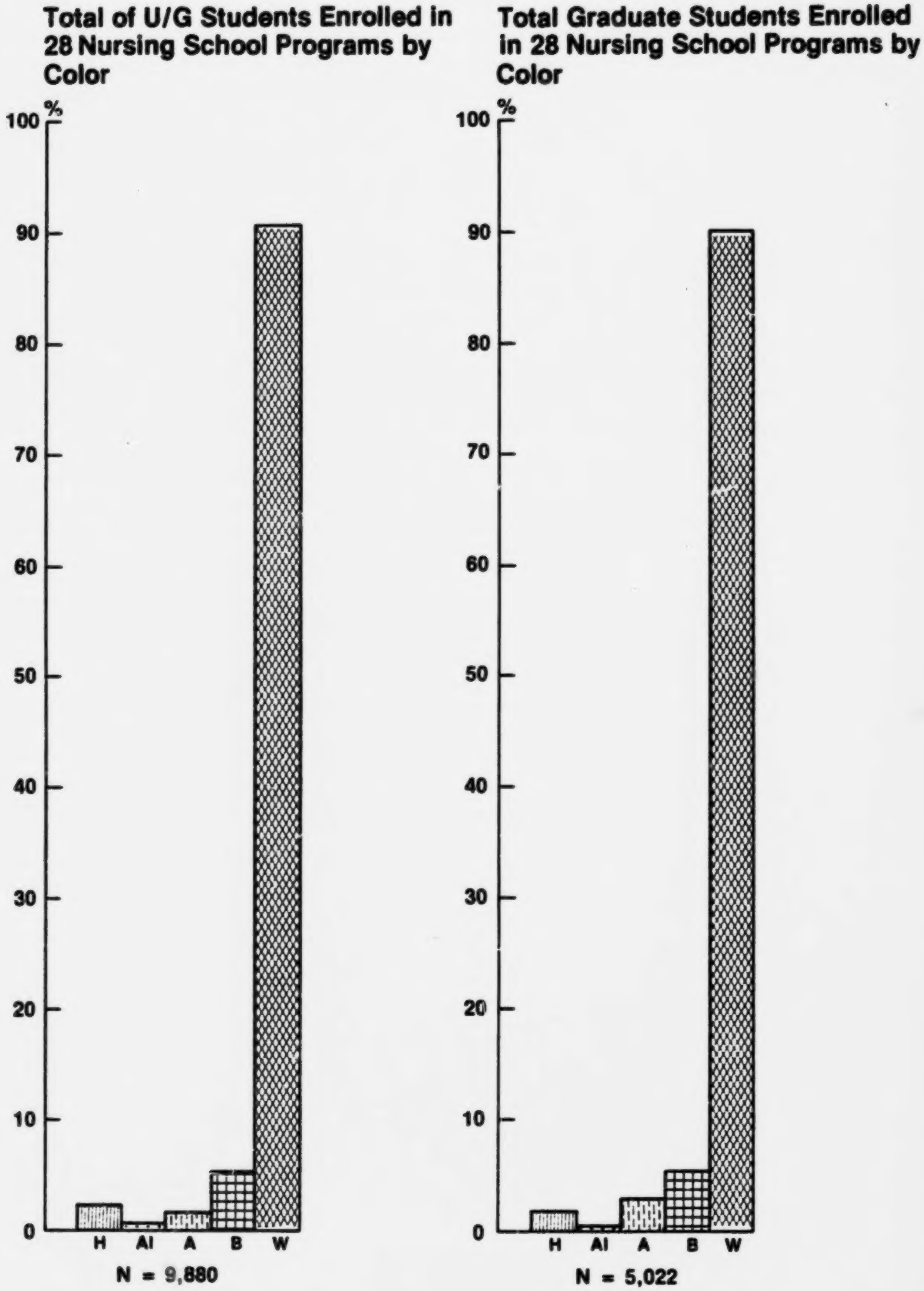
FIGURE 2

COMPARISON OF GRADUATIONS OF NURSES FROM MASTER'S PROGRAMS IN U.S. BY CONTENT AREA, 1976-77 AND 1977-78



NLN Nursing Data Book (Pub. #19-1751, p. 52)
(Pub. #19-1797, p. 66)

FIGURE 3



1978

Total of U/G Students Enrolled in 28 Nursing School Programs by Color

Total Graduate Students Enrolled in 28 Nursing School Programs by Color

FIGURE 4

Full Time Faculty in 29 University Schools of Nursing by Color — 1978

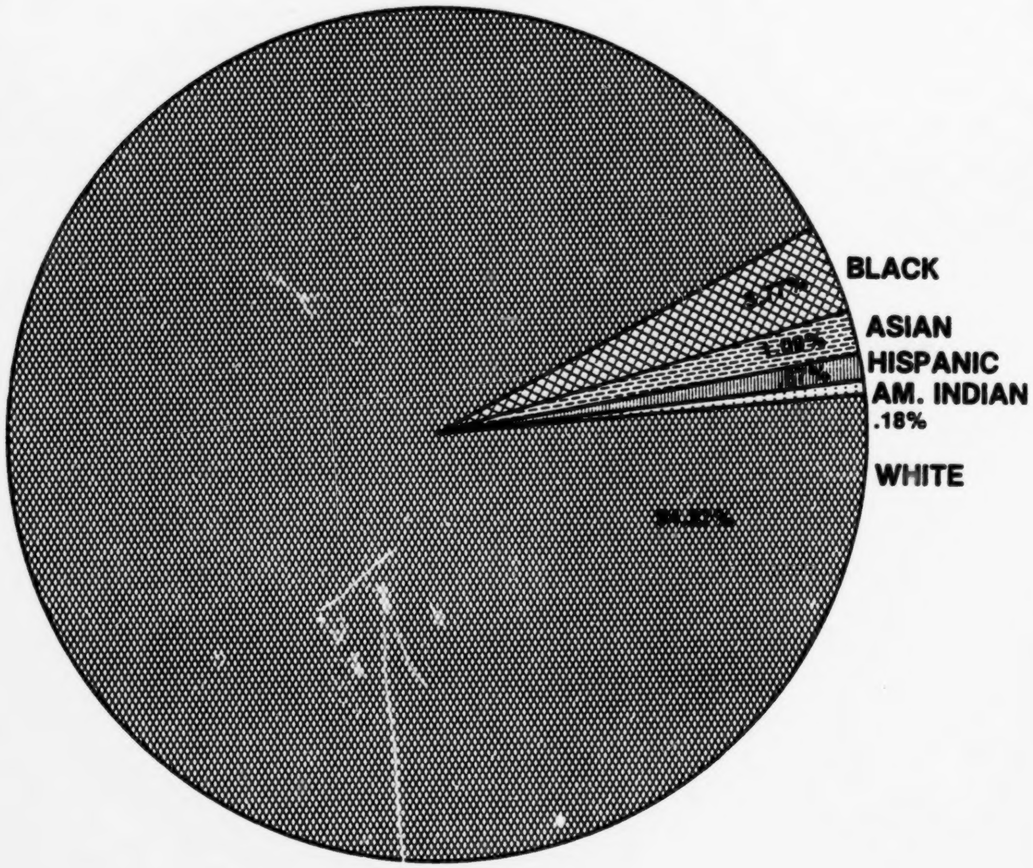


FIGURE 5

Psychiatric Nursing Education
Branch Funded Programs
Average Teaching, Trainee, and Total Program Costs
Combined Program Categories
Fiscal Years 1976 - 1980

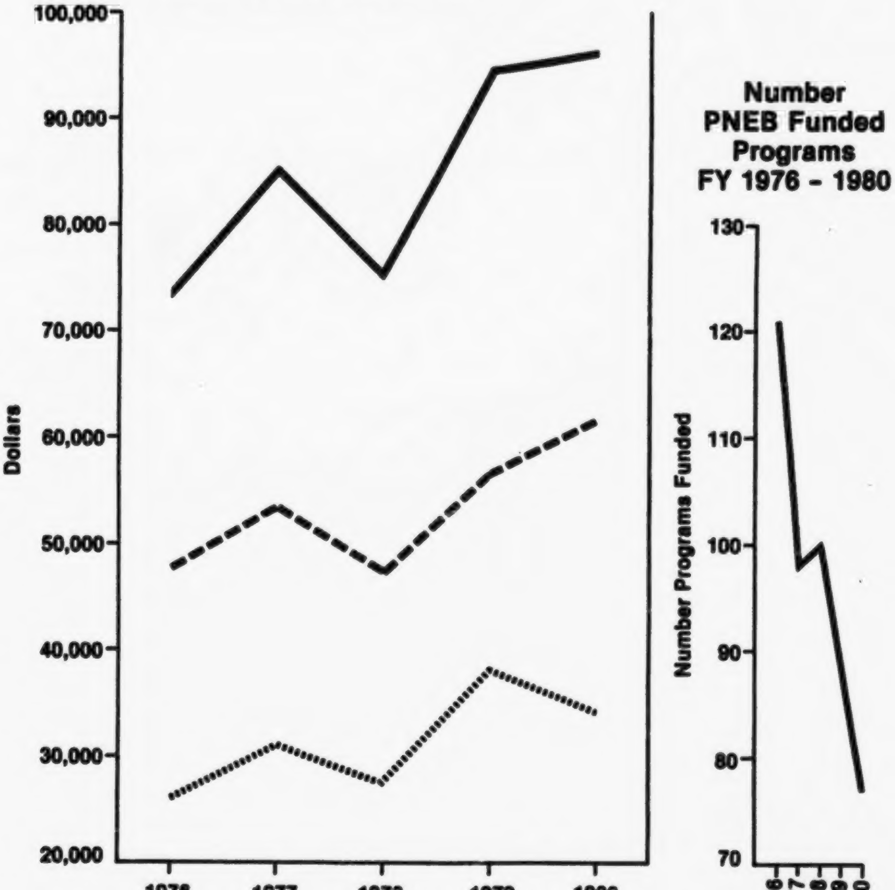


FIGURE 6

PSYCHIATRIC NURSING EDUCATION BRANCH BUDGET ALLOCATIONS FOR FY 1970 THROUGH FY 1981

YEAR	ALLOCATIONS	NUMBER OF STIPENDS AWARDED
1981	$ 7,175,000	784
1980	8,199,294	797
1979	8,453,981	890
1978	7,427,000	1,029
1977	7,785,842	1,092
1976	8,134,066	1,271
1975	8,848,977	1,242
1974	12,227,944	1,272
1973	6,010,662	1,224
1972	10,548,807	1,346
1971	9,973,004	1,327
1970	10,607,684	1,377

NATIONAL SURVEY OF CLINICAL AND EDUCATIONAL INTERESTS OF NURSES

A. AN OVERVIEW

Barbara **Lowery**, R.N., Ed.D., F.A.A.N.

In preparation for this conference, Banchik, Miller and I conducted a national survey to gather data on the clinical and educational interests of nurses. Several factors underlie our interest in these data. First, as psychiatric mental health nursing educators we are deeply concerned about the drastic decline in graduate student enrollment in our field since 1968 (see Figure 1 in the article by Chamberlain and Marshall). Second, we are concerned about the number of nursing schools reported to be integrating psychiatric mental health concepts into the undergraduate curriculum to the extent that no specific undergraduate psychiatric nursing experience exists. Third, it is our perception that the current national nursing shortage has magnified the problems which we have always faced in recruitment to the specialty. We believe that recommendations which result from this conference will relate to these problems. Our purpose is to present our preliminary findings so that you may use them as data upon which your small group discussions and recommendations can be based.

For purposes of this presentation, I will give an overview of the project and its methodology and a summary of some of the overall findings which are relevant to the integration issue.

Banchik and Miller will then present more specific data on clinical and educational interests of service nurses and current nursing students.

Purpose

The purposes of the survey were to determine:

1. Which clinical fields are of most interest to nurses and which are of least interest?
2. What are the reasons for interest or lack of interest in a particular field?
3. What motivates nurses to attend graduate school?
4. What motivates nurses to take a particular job?

The investigators were primarily interested in answering these questions in relation to psychiatric mental health nursing. The general sample was used to elicit data about the field from nurses with different clinical interests. The survey was conducted in such a way that the specific interest of the investigators in psychiatric mental health nursing was not known to the respondents.

Sample Design and Data Collection Procedures

The target population for this study was initially divided into subgroups or strata. These strata were:

1. Senior nursing students in NLN accredited BSN programs.
2. Students in NLN accredited Master's programs.
3. BSN nurses employed in public and private general hospitals.
4. BSN nurses employed in public and private psychiatric hospitals.

Questionnaires were designed for strata 1 and 2 separately and for 3 and 4 combined. It should be noted that, although questionnaires were not identical across strata, there were a number of common questions asked of all respondents.

The technical design of the sample was dictated by the fact that no complete census of individuals in these four strata exists. It was possible, however, to obtain complete lists of institutions within each stratum, i.e., all institutions in the U.S. offering NLN accredited BSN and MSN programs, and all public and private general and psychiatric hospitals in the U.S.

The lists of BSN and Master's programs were derived from data published by the National League for Nursing (1979a, 1979b), while the lists for general and psychiatric hospitals were based on data from the American Hospital Association (1979).

With these lists in hand the sampling proceeded as follows: Within each stratum a certain number of institutions was sampled randomly. If an institution was selected, questionnaires were mailed to those institutions for completion by all BSN's in the stratum. In some cases the number of BSN nurses within institutions was known prior to data collection. If it was not, a number of questionnaires estimated to be sufficient was mailed and data on the actual number of nurses within institutions were collected upon return of the questionnaires.

Technically, the sample design is a stratified, two-stage cluster sample (see, e.g., Cochran, 1977) within the four strata noted above; clusters (i.e., institutions) were sampled at the first stage, and nurses within institutions were sampled at the second stage.

It is most important to realize that the sample design must be kept in mind when making statistical comparisons with these data. In fact, different observations do not necessarily have the same probability of appearing in the sample, due to different sampling rates within strata and within institutions. However, this probability may be computed for each response in the sample, and is used in creating a sample weight. These weights are used in the computation of means and percentages presented here to ensure that these quantities are unbiased estimates of the corresponding population means and percentages.

At this point we have approximately a 20% return rate. The N for each stratum is as follows:

BSN Seniors	322
MSN Students	223
General Hospital BSN's	249
Psychiatric Hospital BSN's	171

Table 1 shows the demographic characteristics of the nurses who have responded to date. As might be expected, the respondents tended to be female and white and about 55% were married. The majority earned (or expected to earn) a salary within the $15,000 to $20,000 range. The mean age of the sample was 30.3 years.

Table 2 shows the mean number of days in clinical practice spent in each of the specialty areas by respondents in the total sample during their BSN program. The question asked here was: "In terms of your BSN program, please specify the approximate amount of clinical time you spent in the specific area noted." The following areas were listed, with space for respondents to record the total number of days spent in each: Medical/Surgical Unit, Public Health Facility, Maternity Unit, Pediatric Unit or Facility, Psychiatric Unit or Facility, and Other. It is important to note that respondents were reporting on days spent in clinical experience in a specialty setting and not on days which might be counted under integrated curricula.

Of importance in Table 2 is the fact that although the total sample had fewer days in psychiatric mental health nursing than in the medical/surgical area, it is obvious that psychiatric mental health nursing cannot be judged as the least visible specialty in terms of number of days of actual practice. In fact, with the exception of the medical/surgical area, respondents spent more time in the psychiatric mental health area than in any of the other specialty areas reported.

Table 3 shows the relationship between the number of days of undergraduate clinical practice in specialty areas and the choice of psychiatric mental health nursing as a field. Those who chose psychiatric nursing as a field clearly had more undergraduate clinical experience in the field than those who chose other fields (38.9--23.4). Since those in the psychiatric sample were older, however, they also had more experience in all the other specialty areas.

While further analyses of the data are necessary, the preliminary analyses do not support the contention that a reduced number of clinical days in our specialty in BSN programs is responsible

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF TOTAL SAMPLE
(N = 949)

Characteristic	Percent
Sex	
Male	3.6
Female	96.4
Race	
White	82.1
Black	14.0
Hispanic	0.6
Asian	2.2
Other	1.1
Marital Status	
Married	55.1
Single	44.9
Salary (Earned or expected)	
Under $10,000	6.3
$10,000-$14,999	14.5
$15,000-$19,999	51.7
$20,000-$24,999	23.1
$25,000-$29,999	3.5
$30,000-$34,999	0.5
$35,000 & over	0.4

for the decline in interest in psychiatric mental health nursing.

The fact that the total number of undergraduate clinical practice days averages about 130 is another interesting point. While it is the subject for a different paper, those of you concerned with the lack of practice skills of graduating nurses might want to make a note of it.

The percentage of BSN seniors preferring specific clinical areas in terms of future employment is shown in Table 4. The psychiatric area was the least popular among the specific areas offered as choices, with less than 5% choosing this area.

TABLE 2

MEAN NUMBER OF DAYS OF UNDERGRADUATE CLINICAL EXPERIENCE OF TOTAL SAMPLE BY PRACTICE AREA
(N = 949)

Practice Area	Number of Days[a]	
	Mean	S.D.
Medical/Surgical	46.7	37.3
Psychiatric	24.4	17.5
Public Health	22.8	18.7
Maternity	22.0	14.9
Pediatrics	21.6	14.0
Other	18.4	13.6

[a] Based on response to question: "In terms of your BSN program, please specify the approximate amount of clinical time you spent in the specific area noted - otherwise leave blank."

TABLE 3

MEAN NUMBER OF DAYS OF UNDERGRADUATE CLINICAL EXPERIENCE OF TOTAL SAMPLE BY CHOICE OF FIELD AND CLINICAL AREA
(N = 949)

Clinical Area	Choice of Field			
	Psychiatric[a]		Non-Psychiatric	
	Mean[b]	S.D.	Mean[b]	S.D.
Medical/Surgical	57.5	35.9	45.8	37.2
Public Health	22.8	15.4	22.8	18.9
Maternity	35.9	18.7	21.0	14.1
Pediatrics	36.1	18.7	20.7	13.1
Psychiatric	38.9	20.0	23.4	16.4
Other	20.8	12.8	18.4	13.7

[a] Psychiatric sample is older, therefore educated when all undergraduate clinical experiences were longer.

[b] Based on response to question quoted in note to Table 2.

TABLE 4

CLINICAL AREA OF MOST INTEREST: BSN SENIORS[a]
(N = 322)

Clinical Area of Most Interest	Percent
Medical/Surgical	44.4
Other	18.9
Pediatrics	14.6
Maternity	10.8
Public Health	6.3
Psychiatric	4.9

[a] Based on response to the question: "In terms of your future employment what is your preferred clinical interest? Circle one:"

Table 5 shows the immediate plans after graduation of the BSN respondents. Only 7% of the students have plans involving graduate school or other alternative to immediate employment.

TABLE 5

PLANS AFTER GRADUATION: BSN SENIORS[a]
(N = 322)

Plans After Graduation	Percent
Employment	93.2
Graduate School	3.5
Other	3.3

[a] Based on response to the question: "Which of the following best describes immediate plans following graduation from your BSN program. Circle one or fill in blank. a. Employment; b. Graduate School; c. Other______________."

Dr. Maloney notes in her paper a persistent view in nursing that new graduates should get a year of some general hospital practice before considering specialty practice. What is obvious is that not only fields such as public health and psych are hurt by this unwritten rule, but that few, if any, of our graduates consider immediate further education, a situation which may not be to the advantage of nursing's future.

Table 6 shows the responses of MSN students to a question seeking to determine the clinical area which interested them least. This table shows again that psychiatric mental health nursing has major problems. Table 7 shows similar data for BSN's employed in general hospitals.

TABLE 6

CLINICAL AREA OF LEAST INTEREST: MSN STUDENTS[a]
(N = 223)

Clinical Area of Least Interest	Percent
Psychiatric	32.1
Maternity	30.6
Medical/Surgical	27.0
Public Health	6.4
Other	3.9

[a] Based on response to the question: "Of the clinical areas listed below, which is of the least interest to you?"

TABLE 7

CLINICAL AREA OF LEAST INTEREST:
BSN's EMPLOYED IN GENERAL HOSPITALS[a]
(N = 249)

Clinical Area of Least Interest	Percent
Psychiatric	43.2
Public Health	23.9
Maternity	14.8
Medical/Surgical	11.9
Other	6.2

[a] Based on response to the question quoted in note to Table 6.

For both the MSN's and the General Hospital nurses the reasons for lack of interest in a particular field are noted in the presentations to be given by Banchik and Miller. It should be noted here, however, that 38% of the MSN students and 46% of the General Hospital nurses gave negative undergraduate experience as a reason for lack of interest in a particular field. It should be noted that the category "Other" was chosen quite frequently as a reason. A check on these "Other" reasons is clearly in order.

While none of the data thus far presented speak directly to the impact of integration on the lack of interest in psychiatric mental health nursing, Table 8 does shed light on this problem.

TABLE 8

NUMBER OF UNDERGRADUATE DAYS IN PSYCHIATRIC NURSING FOR NURSES CHOOSING PSYCHIATRIC NURSING AS CLINICAL AREA OF LEAST INTEREST BY NEGATIVE UNDERGRADUATE EXPERIENCE

Reason for Lack of Interest	Undergraduate Days in Psychiatric Nursing	
	Mean	S.D.
Negative undergraduate experience	27.5	18.8
Reason other than negative undergraduate experience	18.7	11.9

For those who chose psychiatric mental health nursing as their area of least interest--and recall that many have done so--we tried to determine whether the amount of time or the quality of the time spent was responsible for their lack of interest.

The results are clear. Those who didn't like psych because they had had a negative undergraduate experience in it had an average of 27.5 undergraduate days in a psychiatric unit or hospital. Those giving other reasons had a total of 18.7 undergraduate psych days. While further data analyses are essential here, there is no doubt that undergraduate psychiatric nursing experience is viewed negatively by too many nurses.

With respect to integration, at least two possibilities might account for these results:

1. The "filtering" of integration ideas into graduate education might be producing faculties unable to convey the knowledge and enthusiasm necessary to generate positive experiences. The need for further study of this hypothesis was noted earlier.

2. The integration of psychiatric mental health concepts may have resulted in repetition of content when specialty practice occurs. Or, worse yet, the integration may appear to center on acute or crisis episodes while the specialty content centers on long-term chronic illness. Given such a view, students may not see the range of psychiatric mental health nursing practice which includes primary, secondary, and tertiary concerns.

Maybe, on the other hand, the problem we have has nothing to do with integration. Our data suggest that we need to look more carefully at undergraduate offerings in psychiatric mental health nursing. We might ask, for example:

1. Which faculty are assigned to teach these courses? (I suspect those with the least experience often draw such assignments), and
2. What kind of agencies serve as examples of current psychiatric mental health care? I know of many where students witness seclusion, ETC, restraints, heavy medication and few, if any, role models of the psychiatric nurse actually caring for patients.

While it might feel comfortable for the moment to lay the blame for our ills on integration, I believe the more productive approach at this time lies in a review of our own specialty's teaching and service practices.

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B. SURVEY OF EMPLOYED NURSES WITH BSN's

Doris Banchik, R.N., M.S.N.

The purpose of this investigation was to explore differences and similarities between BSN's employed in psychiatric and non-psychiatric settings, particularly as related to the factors that influenced the respondents' choice of specialty area for practice. Our intention was to collect data that would earmark problems and concerns related to the declining interest in psychiatric mental health nursing. We believed that with a clearer understanding of the values of our market, namely nurses, we could attempt to make the changes necessary to improve the attractiveness of psychiatric mental health nursing.

The survey methods and questionnaires used were those previously described by Lowery. The stratified sample included two groups. The first consisted of BSN's employed in general hospitals (N = 249). (Seven percent of this group were employed in psychiatric services in general hospitals). The second group consisted of BSN's employed in public and private psychiatric hospitals (N = 171).

This report begins with the demographic characteristics of the sample. This is followed by data related to the undergraduate curricula of the respondents, descriptions of their current clinical positions, factors influencing their decisions to work in these positions, then an examination of the clinical areas of least interest to the respondents and their reasons for such lack of interest. Data will then be presented on the proportion of the sample enrolled in some type of graduate program in addition to employment. For employed nurses not enrolled in any type of graduate study, data will be reported relating to the degree of interest in attending graduate school at some future date. The importance of various factors influencing these nurses in their desire to attend graduate school, and of factors influencing their interest in a major field of graduate study, will be shown. The report will conclude with an examination of those factors which influenced some nurses to indicate no interest in graduate study. I would like to stress that the differences noted in this report are not necessarily significant.

Table 1 shows demographic data for each group in the sample. Respondents in the psychiatric hospital sample were older, although the age ranges were quite similar. There was a larger proportion of men in the psychiatric hospital sample. While the marital status distribution in the groups was similar, a decidedly higher percentage of nurses employed in psychiatric hospitals had children. This seems logical in view of the difference in ages between the two groups. One can assume that the presence of children in a family affects its geographical mobility, which may account in part for the longer term of employment in the psychiatric hospital group (shown in Table 3). The racial distribution in the groups was about equal, with descending frequencies from White to Black to

Asian to Hispanic.

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF EMPLOYED BSN's BY HOSPITAL TYPE

Characteristic	Psychiatric Hospital (N = 171)	General Hospital (N = 249)
Age (years)		
Mean	40	31
Range	23-71	21-68
Sex		
%Female	88	97
%Male	12	3
Marital Status		
%Married	64	60
%Single	36	40
Race		
%White	78	80
%Black	12	16
%Asian	6	2
%Hispanic	0.3	0.5
%Other	3.7	1.5
Children		
%With	72	46
%Without	28	54

The data in Table 2 were collected in an effort to determine if there were differences between the groups in the undergraduate curricula, specifically in number of courses and number of clinical experience days in each specialty area. The investigators were particularly interested in differences in the psychiatric nursing curricula between the groups. Although there are apparently no major differences between the two groups in number of courses by specialty area, the data on total clinical days show substantial differences, particularly in the medical/surgical and psychiatric areas. There was an average of fourteen more clinical days in the undergraduate psychiatric nursing rotation of the psychiatric hospital respondents than in the psychiatric nursing rotation of

TABLE 2

DESCRIPTION OF UNDERGRADUATE COURSE/CLINICAL WORK BY HOSPITAL TYPE

Clinical Area	Psychiatric Hospital (N = 171)	General Hospital (N = 249)
	Mean Number of Courses	
Medical/Surgical	2.6	2.8
Public Health	1.5	1.5
Maternity	1.5	1.4
Pediatrics	1.5	1.4
Psychiatric	1.9	1.6
	Total Hospital Days	
Medical/Surgical	60	49
Public Health	23	24
Maternity	31	23
Pediatrics	30	22
Psychiatric	40	26

the general hospital respondents. Another way to put this is that the undergraduate psychiatric nursing rotation of the nurses employed in psychiatric hospitals was, on the average, more than 50% greater than the same rotation in the undergraduate curricula of the general hospital respondents. While the other differences were not as great, the psychiatric hospital group showed more clinical days in every rotation except public health. One can assume that, in general, nurses in the psychiatric hospital sample had greater exposure to patient care in their undergraduate programs than did those in the general hospital sample.

Table 3 provides a description of several dimensions of the current clinical positions held by the two groups. Unfortunately, we haven't had the time to analyze the categories listed under "Other" in our data; it would be interesting to know what clinical areas are represented by the 2% of the psychiatric hospital group and the 40% of the general hospital group who were employed in areas other than the specific ones mentioned. The major known clinical area of employment of the general hospital group was medical/surgical. Of

TABLE 3

CHARACTERISTICS OF CURRENT CLINICAL POSITION BY HOSPITAL TYPE

Characteristic	Psychiatric Hospital (N = 171)	General Hospital (N = 249)
Current Clinical Area		
%Medical/Surgical	--	38
%Maternity	--	10
%Psychiatric	98	7
%Pediatrics	--	5
%Other	2	40
Years in Current Position		
Mean	3.6	2.8
Range	1-20	1-28
Current Position		
%Staff nurse	27	65
%Head nurse	5	12
%Supervisor	20	7
%Director	3	1
%Other	45	15
Current Primary Responsibilities[a]		
%Patient care	55	78
%Administration	62	42
Salary (Annual)		
%Under $10,000	1	8
%$10,000-$14,000	10	15
%$15,000-$19,999	53	49
%$20,000-$24,000	28	24
%$25,000-$29,000	7	3
%$30,000-$34,000	1	1

[a] Percentages total more than 100 because some nurses had primary responsibilities in both areas.

the 40% of the general hospital group who checked "Other" as their area of employment, we suspect that a substantial number might have had positions in ambulatory care or perhaps the OR. I would imagine that some nurse administrators and nurse educators did not fit neatly into any of the categories listed on the questionnaire.

As noted earlier, on the average the nurses in the psychiatric hospital group had been in their current positions longer than those in the general hospital group, the mean number of years in current position for the psychiatric hospital group being 0.8 years higher than the mean for the general hospital group. A substantial difference is noted between the groups in percentage of respondents in staff nurse positions (27% in the psychiatric hospital group, 65% in the general hospital group). These data are consistent with the higher age and longer time in practice of the nurses in the psychiatric hospital group. However, given the higher percentages of psychiatric hospital respondents in the supervisor and director of nursing categories, we might be picking up a trend for BSN's in psychiatric hospitals--particularly publicly supported hospitals--to assume administrative positions faster than is the case in the general hospital, where BSN's are more often placed in staff nurse positions. Again, we have a large group of respondents with positions outside of the named categories, as can be seen in Table 3. One possible position for nurses who checked the "Other" category is inservice education.

Commensurate with these data, we found a larger percentage of the general hospital group with primary responsibilities in patient care, and a larger percentage of the psychiatric hospital group with primary administrative responsibilities. Obviously, some respondents from each group have primary responsibilities in both areas, as the totals are well above 100% in both groups. The salary data suggest slightly higher salaries among the psychiatric hospital respondents. The general hospital group includes slightly higher percentages in the two lowest salary ranges, and the psychiatric hospital group shows slightly higher percentages in the next three highest ranges. Twenty-three percent of the general hospital group, versus eleven percent of the psychiatric hospital group, fell in the Under $10,000-$14,999 range, and 76% of the general hospital group, versus 88% of the psychiatric hospital group, fell in the $15,000-$29,000 range. The differences may be accounted for by the longer time in current position and the higher percentage of administrators in the psychiatric hospital group.

Table 4 shows data on the importance of certain factors influencing the respondents' decisions to take their current positions. The respondents were asked to rate, on a 5-point scale, the importance of each factor listed in their decision to work in the current position (with 1 equalling "not very important" and 5 equalling "very important"). Table 4 includes the mean score on each of the items included in this question and the rank order of these scores, with rank number 1 being assigned to the highest mean (most important). The factors are listed in the table in the rank order of

TABLE 4

FACTORS INFLUENCING DECISION TO TAKE CURRENT POSITION BY HOSPITAL TYPE

Factor	Psychiatric Hospital (N = 171)		General Hospital (N = 249)	
	Mean[a]	Rank Order	Mean[a]	Rank Order
More independence	3.9	1	3.5	3
Salary increase	3.8	2.5	3.2	4
Additional learning opportunities	3.8	2.5	.0	1
Other	3.7	4	3.9	2
Increased status	3.5	5	2.6	9
Proximity to home	3.2	6	3.0	5
Past personal experience with this kind of setting	3.0	7	2.9	6
Positive undergraduate experience in this area	2.9	8	2.8	7.5
Frustration with former work	2.8	9	2.8	7.5
Presence of particular individuals	2.5	10	2.0	11.5
Recommendation(s) of friend/associate/relative	2.3	11.5	2.3	10
Advertising/recruiting	2.3	11.5	2.0	11.5
Only job available	1.7	13	1.6	13

[a] Based on response to the question: "How important were the following factors in your decision to work in your current job? Circle one for each item.

	Not very Important		Important		Very Important"
Item	1	2	3	4	5

the scores for the psychiatric hospital group. The five most important factors in the decision of the psychiatric hospital group were: more independence, salary increase, additional learning opportunities, other, and increased status. The five most important factors influencing the decision of the general hospital group were: additional learning opportunities, other, more independence, salary increase, and proximity to home (which was rank number 6 in the psychiatric hospital group).

Looking at factors of lesser importance in the decision of nurses in the two groups we find the following. For the psychiatric hospital group the five factors of lesser importance were (in order of least importance): only job available, advertising/ recruiting, recommendation(s) of friend/associate/relative, presence of particular individuals, and frustration with former work. For the general hospital group the five factors of lesser importance were (in order of least importance): only job available, advertising/recruiting, presence of particular individuals, recommendation(s) of friend/associate/relative, and increased status.

As can be noted, most of the factors were fairly equal in importance to nurses in both groups. With one exception, all rank order numbers for the two groups differ by 2 or less. It is interesting to note that this one exception is the factor of "increased status," which has a rank order of number 5 (with a mean score of 3.5) for the psychiatric hospital group, but a rank order of number 9 (with a mean score of 2.6) for the general hospital group.

I might point out that the mean score of the importance of a positive undergraduate experience in this decision falls in the middle of the scale for both groups (with a rank order of number 7 for the psychiatric group and a rank order of number 7.5 for the general hospital group). Since we had assumed that this factor would be more important in the decision to work in a particular clinical area, I examined the data a bit more closely in Table 5.

Table 5 shows the mean scores of the respondents on the question of importance of the factors influencing the decision to work in current position by specialty area. This table does not include data from respondents in the general hospital group who checked "other" as their area of employment. The most consistent, fairly important factors across the four areas for the general hospital group seem to be: more salary (with the exception of maternity), more independence, positive undergraduate experience (the difference between the means for this factor in Table 5 and the mean for the total general hospital group shown in Table 4, suggests that the nurses in the "other" category, with a mean of 2.3, were working in areas uncommon to the standard undergraduate rotations, e.g., ambulatory care), learning opportunities (except for pediatrics), and "other." The factors consistently of lesser importance for the general hospital respondents were: presence of particular individuals, advertising/recruiting, recommendation(s) of friend/associate/ relative, and only job available (except for pediatrics, for which this seemed to be a fairly important factor). I might point out that the mean scores for the maternity group were lowest on eight of the 13 factors, and highest on 2 factors--frustration with former work, and additional learning opportunities. This is an interesting finding in view of data which will be presented in Table 6, which shows that maternity was by far the least interesting

TABLE 5

FACTORS INFLUENCING DECISION TO TAKE CURRENT POSITION BY CLINICAL AREA AND HOSPITAL TYPE

Factor	Psych Hosp	General Hospital[a] (N = 128)			
	Psych	Med/ Surg	Mat	Peds	Psych
	Mean[b]	Mean[b]	Mean[b]	Mean[b]	Mean[b]
More independence	3.9	3.4	3.3	3.3	3.4
Salary increase	3.8	3.4	2.2	3.7	3.5
Additional learning opportunities	3.8	4.1	4.1	2.8	4.0
Other	3.7	3.5	3.5	5.0	5.0
Increased status	3.5	2.8	1.7	2.4	2.8
Proximity to home	3.2	3.2	2.6	3.3	2.8
Past personal experience in this kind of setting	3.0	2.9	2.5	3.2	4.3
Positive undergraduate experience in this area	2.9	3.0	3.6	3.4	3.7
Frustration with former work	2.8	2.7	3.5	2.5	2.0
Presence of particular individuals	2.5	2.0	1.6	2.2	2.6
Recommendation(s) of friend/associate/relative	2.3	2.4	2.3	1.7	1.9
Advertising/recruiting	2.3	2.1	1.9	2.2	1.9
Only job available	1.7	1.5	1.2	3.6	1.6

a Does not include a total of 121 respondents who were working in clinical areas other than those listed here (108) or did not report their current clinical area (13).

b Mean scores based on response to question quoted in note to Table 4.

area for the psychiatric hospital nurses.

Psychiatric nurses employed in general hospitals formed too small a group (N = 12) to make much of the data comparatively. However, the data from that group indicate that "frustration with former work" was less important in the decision to take their current position than for nurses employed in the other three clinical areas in general hospitals. A positive undergraduate experience was more important to nurses in the psychiatric area in general hospitals than for nurses employed in the other clinical areas in this type of hospital. Other factors of more importance to the psychiatric nurses in general hospitals than for nurses in the other areas were "presence of particular individuals" and "past personal experience with this kind of setting."

The data for the psychiatric hospital group were presented in Table 4 as well as in Table 5. Looking across the five groups, as shown in Table 5, the psychiatric hospital respondents had the highest mean scores for: salary increase, increased status, more independence, and advertising/recruiting. The mean score for the psychiatric hospital group on the importance of a positive undergraduate experience was the lowest among the five groups. The group from which the psychiatric hospital sample seemed to vary most was maternity. Interesting, but perhaps meaningless, differences between psychiatric nurses employed in general hospitals and those employed in psychiatric hospitals include: "past personal experience in this kind of setting" and "positive undergraduate experience," with the scores for psychiatric nurses in general hospitals being higher for both factors, and "frustration with former work," with scores for nurses in psychiatric hospitals being higher than those for psychiatric nurses employed in general hospitals.

Table 6 shows the distribution of responses in the two groups to the question, "Of the clinical areas listed, which is of least interest to you?" As indicated earlier, 51% of the psychiatric hospital sample chose maternity, followed by another 33% who chose medical/surgical nursing. The responses of the general hospital group were most discouraging--the area of least interest in that group was psychiatric nursing, with 43% choosing this area. The general hospital group selected public health as the second least interesting area, with 24% naming this area.

TABLE 6

CLINICAL AREA OF LEAST INTEREST BY HOSPITAL TYPE

Clinical Area of Least Interest	Psychiatric Hospital (N = 171) Percent	General Hospital (N = 249) Percent
Maternity	51	15
Medical/Surgical	33	12
Public Health	12	24
Other	4	6
Psychiatric	0	43

Table 7 shows the distributions for each of the two groups on the reasons respondents gave for choosing their areas of least interest. More than one-third of each group checked the "Other" category and listed a reason different from the six choices offered in the questionnaire. Unfortunately, these data have not yet been analyzed. However, in the psychiatric hospital group the most frequently chosen of the alternatives offered was "lack of independence in practice in this field," with 33% selecting this reason. The next most frequently selected reason among psychiatric hospital nurses was "negative undergraduate experience," with 17% giving this as the reason. Looking at the responses of the general hospital sample, we note that more than half (52%) gave "negative undergraduate experience" as the reason for their selection of a field of least interest. I might repeat here, that the area of least interest in the general hospital group was clearly psychiatric nursing.

TABLE 7

REASON FOR LACK OF INTEREST IN CLINICAL AREA BY HOSPITAL TYPE[a]

Reason for Lack of Interest	Psychiatric Hospital (N = 171) Percent	General Hospital (N = 249) Percent
Other	38	32
Lack of independence in practice in this field	33	4
Negative undergraduate experience	17	52
No undergraduate clinical experience in this field	7	3
Poor salaries in this field	2	3
No undergraduate course in this field	1	3
Lack of jobs in this field in my geographic area	1	5

[a] Based on response to the question: "What factor contributed most to your lack of interest in the circled above field? Circle one."

Tables 8 and 9 provide for a closer examination of the potential relationships between the clinical area of least interest and the reasons for this lack of interest. In these tables, we placed the selections of areas of least interest along the horizontal axis. On the vertical axis, we listed the choice of reasons for lack of interest in the area. (Each respondent was asked to name the single factor which contributed most to lack of interest in the field of least interest). Thus, we have the distributions of reasons for each clinical area being least interesting. Looking at the data for nurses employed in general hospitals (shown in Table 8), we find "negative undergraduate experience" was chosen as the reason for lack of interest in a clinical area more frequently than any other reason. Fifty-two percent of the respondents in the general hospital sample gave this as a reason for selecting their area of least interest. As shown in Table 8, 43% of the total sample of general hospital respondents selected psychiatric nursing as their area of least interest. Twenty-six percent of the general hospital respondents both selected psychiatric nursing as their area of least interest and gave "negative undergraduate experience" as the reason for such selection. Another way to put this is that over half of the sample who selected psychiatric nursing as least interesting chose a negative undergraduate experience as the reason for this lack of interest.

Data on reasons for lack of interest in specific clinical areas is given for the psychiatric hospital respondents in Table 9. The largest number of responses (38%) was in the category "other" and, as previously noted, the specific areas written on the questionnaire under this category have not yet been analyzed. Since maternity was selected by the highest percentage in the psychiatric hospital group as the area of least interest (with 43% making this choice), we might want to note that 12% of the sample cited the reason for lack of interest in this area as "lack of independence in practice in this field," and 8% cited "negative undergraduate experience" as the reason for lack of interest. Twenty-two percent gave reasons other than the ones offered as choices on the questionnaire for maternity being their area of least interest. Twenty percent in the psychiatric hospital sample chose "lack of independence in practice in this field" as the reason for the lack of interest in medical/surgical nursing. I might add here that over half of the respondents in the psychiatric hospital group who chose public health as the area of least interest, gave as the reason "no undergraduate clinical experience in this field."

Tables 10, 11 and 12 present data on various aspects of graduate study in relation to nurses employed in general and psychiatric hospitals.

As shown in Table 10, only 16% of the psychiatric hospital group and 11% of the general hospital group were enrolled in graduate programs at the time of the study. Of this relatively small number enrolled, approximately 40% in each group indicated they were attending on a full time basis.

Table 11 shows data on the degree of interest in graduate study among nurses not enrolled in a graduate program at the time of the survey. In the psychiatric hospital group, 82% indicated that they were either "very interested" or "interested," while 69% of the general hospital group indicated a similar interest. The percentage

TABLE 8

REASON FOR LACK OF INTEREST IN CLINICAL AREA: BSN's EMPLOYED IN GENERAL HOSPITALS (N = 249)

Reason for[a] Lack of Interest	Clinical Area of Least Interest					
	Total %	Med/surg %	Maternity %	Psych %	PubHl %	Other %
Total	100.0[b]	13	14	43	27	5
No undergrad course in this field	3	0	0	0	3	0
No undergrad clinical experience in this field	3	1	1	1	0	0
Negative undergrad experience	52	6	6	26	11	3
Lack of jobs in this field in area	5	0	0	1	3	1
Poor salaries in this field	3	0	0	0	3	0
Lack of independence in practice in this field	4	2	1	0	1	0
Other	32	4	6	15	6	1

[a] Based on response to question: "What factor contributed most to your lack of interest in the circled above field? Circle one."

[b] Total is more than 100.0 due to rounding.

TABLE 9

REASON FOR LACK OF INTEREST IN CLINICAL AREA: BSN's EMPLOYED IN PSYCHIATRIC HOSPITALS (N = 171)

Reason for[a] Lack of Interest	Clinical Area of Least Interest					
	Total %	Med/surg %	Maternity %	Psych %	PubHl %	Other %
Total	100.0	37	43	0	13	6
No undergrad course in this field	1	0	0	0	1	0
No undergrad clinical experience in this field	7	0	0	0	7	0
Negative undergrad experience	17	4	8	0	3	2
Lack of jobs in this field in area	1	0	1	0	0	0
Poor salaries in this field	2	1	0	0	1	0
Lack of independence in practice in this field	33	20	12	0	0	1
Other	38	12	22	0	1	3

a Based on response to question: "What factor contributed most to your lack of interest in the circled above field? Circle one."

TABLE 10

GRADUATE SCHOOL STATUS OF EMPLOYED NURSES BY HOSPITAL TYPE

Graduate School Status	Psychiatric Hospital (N = 171) Percent	General Hospital (N = 249) Percent
Currently enrolled in graduate school		
Yes	16	11
No	84	89
Attendance status (If enrolled)		
Full time	38	43
Part time	62	57

TABLE 11

EMPLOYED NURSES' INTEREST IN GRADUATE STUDY BY HOSPITAL TYPE

Degree of[b] Interest	Psychiatric[a] Hospital (N = 135) Percent	General[a] Hospital (N = 208) Percent
Very interested/ Interested	82	69
Indifferent/ Not interested/ Definitely not interested	18	31

[a] Includes only those nurses not currently enrolled in graduate school.

[b] Based on response to question: "How interested are you in graduate study? a. Very interested, b. Interested, c. Indifferent, d. Not interested, e. Definitely not interested.

of nurses indicating no interest or indifference, was 18% for the psychiatric hospital group and 31% for the general hospital group.

Table 12 shows the relative importance of the factors influencing nurses not taking graduate work to have an interest in pursuing graduate study at some future time. Respondents indicating such an interest (as shown in Table 11) were asked to rate the importance of each of eight specific factors in relation to this interest and to rate the importance of any other factor which they might wish to list. The 5-point scale used in these ratings (shown in the note to Table 4) allowed respondents to rate the importance of each item, with 1 representing the extreme of "not very important" and 5 representing the other extreme of "very important." The factors rated are listed in Table 12 in rank order by the mean scores on the items for the psychiatric hospital group. The mean score and the number of the rank are shown for each item for both groups.

In the psychiatric hospital group, nurses interested in graduate education scored the following factors as most important in influencing their interest (in order of importance): salary increase, increase in status, more independence, and recommendation(s) of friend/associate/relative. The factors that seemed of least importance in influencing the interest of the psychiatric hospital group in graduate education were (in order of least importance): advertising/recruiting, presence of particular faculty, other, and encouragement of faculty in undergraduate program.

In the general hospital group, nurses interested in graduate education scored the following factors as most important (in order of importance): more independence, salary increase, increased status and availability of tuition payback from employer. The factors which seemed to be of least importance (in order of least importance) were: advertising/recruiting, recommendation(s) of friend/associate/relative, presence of particular faculty, and other.

The degree of importance of the factors listed in Table 12 is quite similar in the two hospital groups, with one dramatic exception. Whereas eight of the nine items for the two groups are not more than 1.5 ranks apart, there is a difference of four ranks in the mean scores for the importance of "recommendation(s) of friend/associate/relative," the item being rank number 4 for the psychiatric hospital group and rank number 8 for the general hospital group.

We asked the respondents in both groups who indicated an interest in education (see Table 11) to rate the factors listed in Table 13, on a 5-point scale, in terms of their importance in influencing the respondents' interest in a major field of graduate study. This table shows the mean scores for each factor in rank order by the scores for the psychiatric hospital group.

The psychiatric hospital group indicated that the factors most

TABLE 12

FACTORS INFLUENCING INTEREST IN GRADUATE STUDY BY HOSPITAL TYPE

Factors Influencing Interest	Psychiatric Hospital[a] (N = 144)		General Hospital[a] (N = 111)	
	Mean[b]	Rank Order	Mean[b]	Rank Order
Salary increase	4.4	1	3.7	2
Increase in status	4.3	2.5	3.6	3
More independence	4.3	2.5	4.1	1
Recommendation(s) of friend/associate/ relative	4.2	4	2.2	8
Availability of tuition payback from employer	3.5	5	3.4	4
Encouragement of faculty in undergraduate program	2.5	6	2.7	5
Other	2.4	7	2.4	6.5
Presence of particular faculty	2.3	8	2.4	6.5
Advertising/recruiting	1.6	9	1.8	9

a Respondents include only those nurses, not currently attending graduate school, who indicated they were either "very interested" or "interested" in attending graduate school.

b Based on response to question: "How important are the following in your interest to pursue graduate school? Please circle one for each item." (See note to Table 4 for scale used).

important in influencing their interest in a major field of graduate study were (in order of importance); desire to learn, salary increase, more independence, and positive work experience in this area. The factors of least importance to the psychiatric hospital group, in terms of influencing their interest in a major field of study, were (in order of importance): advertising/recruiting, only program available, presence of particular faculty, and positive undergraduate experience in this area.

The general hospital group scored as the most important factors influencing their interest in a major field of graduate study (in order of importance): more independence, salary increase and positive work experience (tied for second and third ranks),

TABLE 13

FACTORS INFLUENCING INTEREST IN A MAJOR FIELD OF STUDY BY HOSPITAL TYPE

Factor	Psychiatric[a] Hospital (N = 111)		General[a] Hospital (N = 144)	
	Mean[b]	Rank Order	Mean[b]	Rank Order
Desire to learn	4.6	1	2.3	7
Salary increase	4.5	2	3.7	2.5
More independence	4.3	3	4.1	1
Positive work experience in this area	4.0	4	3.7	2.5
Frustration with former work	3.5	5	2.9	6
Availability of financial aid in this field	3.0	6	3.3	5
Recommendation(s) of friend/associate/relative	2.8	7	2.2	8
Positive undergraduate experience in this area	2.7	8	3.5	4
Presence of particular faculty	2.2	9	2.0	9
Only program available	1.7	10.5	1.7	11
Advertising/recruiting	1.7	10.5	1.8	10

[a] Includes only those respondents not currently attending graduate school and who answered "Very interested" or "Interested" to the question: "How interested are you in graduate study? a. Very interested, b. Interested c. Indifferent, d. Not interested, e. Definitely not interested." (See note to Table 4 for scale used).

and positive undergraduate experience. The least important factors for the general hospital respondents were (in order of least importance): only program available, advertising/recruiting/ presence of particular faculty, and recommendation(s) of friend/associate/ relative.

As was the case in ranking the importance of factors influencing interest in graduate study (shown in Table 12), there was considerable similarity in the degree of importance attached to the factors influencing interest in a major field of study listed by respondents in the two groups. For nine of the eleven factors listed, difference in rank order between the two groups was 2 ranks or less. The two exceptions were: desire to learn (with the psychiatric hospital group placing this factor as rank number 1 and the general hospital group placing it as rank number 7) and positive undergraduate experience in this area (with the psychiatric hospital group placing this factor as rank number 8 and the general hospital group placing it at rank number 4).

Respondents who indicated no interest or indifference to graduate education were asked to rate the importance of each of a list of factors influencing their lack of interest. The results are shown in Table 14. In the psychiatric hospital group, the factors that seemed to be of most importance in influencing lack of interest in graduate education included (in order of importance): minimal salary increase after MSN in geographic area, no jobs available for MSN's in geographic area and cannot afford graduate studies (tied for second and third ranks) and family responsibilities too great. The least important factors influencing the lack of interest in graduate study for this group were (in order of least importance): other, don't know enough about graduate programs and requirements, cannot meet entrance requirements, and lack of confidence in own abilities.

Scores of the general hospital group suggest the factors of most importance in influencing their lack of interest in graduate education were (in order of importance): other, minimal salary increase after MSN in geographic area and family responsibilities too great (tied for second and third ranks) and cannot or not willing to move. Of least importance in influencing their lack of interest were (in order of least importance): cannot meet entrance requirements, lack of confidence in own abilities, don't know enough about graduate programs and requirements and no jobs for MSN's in my field (tied for eighth and ninth ranks).

The pattern of similarity between the general hospital and the psychiatric hospital groups observed in the ranking of items in Tables 12 and 13 is not observed in Table 14. In contrast to those results, differences greater than 2 ranks are observed for five of the eleven items. (It should be kept in mind that the samples are much smaller in Table 14 than in the other two, so that the results shown in this table may not be as reliable as in the other tables). However, it is interesting to note the dramatic difference in the rank order of "other" factors in the two tables, "other" factors

TABLE 14

FACTORS INFLUENCING LACK OF INTEREST IN GRADUATE STUDY BY HOSPITAL TYPE

Factor	Psychiatric[a] Hospital (N = 24)		General[a] Hospital (N = 64)	
	Mean[b]	Rank Order	Mean[b]	Rank Order
Minimal salary increase after MSN in my geographic area	4.2	1	3.1	2.5
Cannot afford graduate studies	3.0	2.5	2.7	5
No jobs available for MSN's in my geographic area	3.0	2.5	2.2	7
Family responsibilities too great	2.9	4	3.1	2.5
No jobs for MSN's in my field	2.7	5	2.1	8.5
Graduate program not available in town where I live	2.5	6	2.5	6
Cannot or not willing to move	2.2	7	3.0	4
Lack of confidence in my abilities	2.1	8	2.0	10
Cannot meet entrance criteria	1.9	9	1.7	11
Don't know enough about graduate programs and requirements	1.8	10	2.1	8.5
Other	1.7	11	3.4	1

[a] Includes only those respondents not currently attending graduate school and who answered "Indifferent," "Not interested," or "Definitely not interested," to question: "How interested are you in graduate study?"

[b] Mean score based on response to the question: "How important were the following in influencing your lack of interest in graduate study?" (See note to Table 4 for scale used).

being rated as the most important category by the general hospital group, while the psychiatric hospital group assigned this category to the lowest rank--a difference of 10 ranks in position between the two ratings. The two other greatest differences in degree of importance assigned to factors by the two groups related to the availability of jobs for MSN's. In the psychiatric hospital group, no jobs available in my geographic area had a rank order of 2.5, while in the general hospital group this factor was assigned a rank order of 7. In the case of the other factor involving jobs (no jobs for MSN's in my field) this factor was clearly more important for the psychiatric hospital group than for the general hospital group, with the former assigning the factor to rank number 5, compared with rank number 8.5 in the general hospital group.

C. BSN/MSN PRELIMINARY DATA REPORT

Jeanne Miller, R.N., Ph.D.

I would like to discuss with you briefly some of the results of our survey of BSN and MSN students.

Obviously, these are two very important groups to be considered when addressing psychiatric nursing recruitment.

We are concerned about master's students because we wish to know what they think about psychiatric nursing. What motivated them to go to graduate school? Why did they select their particular clinical focus and graduate program? What preparation did they have in psychiatric nursing at the undergraduate level? Finally, we would like to know if master's students in psychiatric nursing can be differentiated from other master's students or practicing psychiatric nurses.

BSN students' interest, or lack of interest, in psychiatric nursing is of great concern. We of course would like to be able to identify why BSN students are or are not interested in psychiatric nursing and/or graduate school in psychiatric nursing. We would like to know how they made their decision to focus their interest in a specific clinical area.

Of course, we would like to be able to describe clearly the general characteristics of BSN, MSN and practicing psychiatric nurses. We are ultimately concerned with identifying some factors which appear to be closely related to interest in psychiatric nursing--we would like to be able to identify some key factors and investigate these further. Finally, we would like to be able to modify experiences of potential psychiatric nurses to stimulate interest and involvement in psychiatric nursing.

While the findings reported here are preliminary, we believe these data throw considerable light on the interests and experiences of BSN and MSN students. Furthermore, they provide the important service of identifying some significant areas for further investigation.

The data presented here are based on mailed questionnaires completed by 322 senior undergraduate students (BSN's) and 223 graduate students (MSN's). The survey methods and questionnaires were previously described by Lowery.

Demographic characteristics of the respondents in the two samples are shown in Table 1.

The range of ages for BSN's is 18-51 and the range for MSN's is 21-51. Eighty-eight percent of the BSN students are age 30 or below. The mean age for BSN's is 25 while the mean age for MSN's is 30.4. Females make up 95% of the BSN sample and 98% of the

MSN sample. Racial configurations of both samples reflect a predominantly white student population. In general, these samples are comprised of predominantly young, white, single and married females. It is interesting to note that there is only a five year difference in mean age between the two samples.

TABLE 1

DEMOGRAPHIC CHARACTERISTICS: BSN AND MSN STUDENTS

Characteristic	BSN (N = 322)	MSN (N = 223)
Age (years)		
Mean	25.0	30.4
Range	(18-51) (88% 30 or below)	(21-51)
Sex		
%Male	5.0	2.2
%Female	95.0	97.8
Marital Status		
%Single	80.0	40.0
%Married	20.0	60.0
Children		
%With	13.0	82.0
%Without	87.0	18.0
Race		
%White	92.0	95.3
%Black	5.0	2.6
%Hispanic	1.3	0.3
%Asian & Other	1.7	1.8

Having identified our respondents, let's consider briefly their interest, or lack of interest, in psychiatric nursing. First, let's consider master's students. As shown in Table 2, 32.1% of all MSN student respondents identify psychiatric nursing as their least favorite clinical area. Maternity was listed by 30.6% as their least favorite area, 27.0% identify medical/surgical and only 6.4% identify public health as their area of least interest.

When BSN students were asked to select their area of most interest

TABLE 2

CLINICAL AREA OF LEAST INTEREST: MSN STUDENTS
(N = 223)

Area of Least Interest	Percent
Psychiatric	32.1
Maternity	30.6
Medical/Surgical	27.0
Public Health	6.4
Other	3.9

(see Table 3), only 4.9% selected psychiatric nursing, while 44.4% selected medical/surgical nursing, 18.9% selected "other" (we believe this includes nurse practitioner), 14.6% selected pediatrics, 10.8% selected maternity, and 6.3% selected public health.

TABLE 3

CLINICAL AREA OF MOST INTEREST: BSN STUDENTS
(N = 322)

Area of Most Interest	Percent
Medical/Surgical	44.4
Other	18.9
Pediatrics	14.6
Maternity	10.8
Public Health	6.3
Psychiatric	4.9

Certainly, of greatest concern to those of us interested in psychiatric nursing is the very low percent of the BSN sample who identify psychiatric nursing as their area of most interest. Historically, psychiatric nursing has not won popularity contests among nurses and our data suggest that we are currently upholding that traditon.

Next, let's consider why students selected their particular area of clinical interest and their reasons for planning to attend graduate school. These data are shown in Tables 4 and 5.

TABLE 4

RANK ORDER OF REASONS FOR SELECTING CLINICAL FIELD:
BSN STUDENTS
(N = 322)

Rank Order[a]	Reason for Selecting Clinical Field
1.	Opportunity for independence
2.	Positive undergraduate clinical experience
3.	Other reasons
4.	Need for more practice in this field
5.	Past work experience in this area
6.	Salary
7.	Status in the field
8.	Faculty
9.	Availability of job
10.	Need for nurses in this field
11.	Frustration with other clinical fields
12.	Recommendation(s) from friend/associate/relative
13.	Advertising/recruitment

[a] Rank order based on mean score for item in response to the question: "How important were the following in your choice of clinical field? Circle one for each:

Item	Not very Important		Important		Very Important"
	1	2	3	4	5

The rank order of reasons given by BSN students for selecting a particular clinical field is preliminary. It is possible that a complete analysis of the total data bank will reveal a different pattern of responses. However, I suspect that BSN students' responses will suggest that they selected their chosen clinical field for the highest ranked reasons as shown in Table 4. According to our preliminary data a positive undergraduate experience appears to be very important in BSN students' selection of their clinical area. It is also of interest that these students do not report advertising and recruitment as being an important factor in their individual selection of clinical focus.

As shown in Table 5, BSN student respondents who planned to enter graduate school immediately after graduation suggested that they chose to do so for reasons related to independence, status and salary.

The rank order of reasons given by MSN students for selecting their field of clinical interest is shown in Table 6.

TABLE 5

RANK ORDER OF REASONS FOR PLANNING TO ATTEND GRADUATE SCHOOL:
BSN STUDENTS
(N = 27)

Rank Order[a]	Reason for Planning to Attend Graduate School
1.	More independence
2.	Increase in status
3.	Salary increase
4.	Encouragement of faculty in undergraduate program
5.	Availability of tuition payback from employer
6.	Recommendation(s) of friend/associate/relative
7.	Other
8.	Presence of particular faculty
9.	Advertising/recruitment

[a] Rank order based on mean score for item in response to the question: "How important were the following in your decision to enter graduate school? Please circle one for each item." (See note to Table 4 for scale used).

Table 7 shows the rank order of reasons given by MSN students for choosing their current school. The most important factor was the existence of a particular clinical or functional program at the school they chose. Second in importance was proximity of the school to their home. Age of the graduate student, marital status and presence or absence of children were significant factors influencing students' scoring of the degree of importance of this item. Reputation of the school chosen was the third most important factor in the selection.

The rank order of reasons given by MSN students for deciding to enter graduate school is shown in Table 8. The most important specific reasons given reflect the judgment of these students that a master's degree would provide them with more independence, and increased status and salary.

TABLE 6

RANK ORDER OF REASONS FOR CHOICE OF A MAJOR FIELD OF STUDY: MSN STUDENTS (N = 223)

Rank Order[a]	Reason for Choice of Major Field of Study
1.	Desire to learn
2.	More independence[b]
3.	Frustration with former work
4.	Positive undergraduate experience in this area
5.	Salary increase
6.	Availability of financial aid[c]

[a] Rank order based on mean score for item in response to the question: "How important were the following in your choice of a major field of study? Please circle one for each item." (See note to Table 4 for scale used).

[b] Virtually all of the sample reported that they believed that going to graduate school would strengthen their independence and that their selected clinical field would permit this greater independence.

[c] While 70% of graduate students received financial aid for full tuition, they do not suggest that this is a particularly strong motive for planning to attend graduate school.

Thus far we have established a rather general picture of our respondents. We know that a relatively large percent of both samples are not interested in psychiatric nursing and we have some idea of why they selected their particular area of clinical interest. Now let's consider the reasons respondents gave for their lack of interest in their area of least interest.

Our data strongly suggest that a negative undergraduate experience in the clinical area of least interest was the highest ranked factor associated with respondents' lack of interest in a specific area. Because of this factor of negative undergraduate experience, we were interested in learning something more about this experience. One idea we held prior to conducting this study was that undergraduates were spending fewer days/hours in psychiatric nursing in integrated curricula than had previous students who were not involved in integrated curricula. To examine this idea more closely we looked at the number of courses and clinical days in psychiatric nursing the BSN, MSN and employed nurses had experienced. While number of courses in psychiatric nursing was relatively constant for all respondents, Table 9 shows clearly what has been happening to clinical experience of undergraduate students.

TABLE 7

RANK ORDER OF REASONS FOR CHOOSING CURRENT SCHOOL:
MSN STUDENTS
(N = 223)

Rank Order[a]	Reason for Choosing Current School
1.	Existence of a particular clinical or functional program
2.	Proximity to home[b]
3.	Reputation of school
4.	Availability of financial aid
5.	Presence of particular faculty members
6.	Advertising/recruitment[c]
7.	Received bachelor's degree from this school
8.	Contact through continuing education program(s)

[a] Rank order based on mean score for item in response to the question: "How important were the following in your choice of your current school for your Master's degree instead of another school? Please circle one for each item." (See note to Table 4 for scale used).

[b] Age of graduate student, marital status, and percent with children were significant factors in the high priority given to this reason.

[c] Advertising/recruitment were not important in the decision of most students.

The number of clinical days in psychiatric nursing during undergraduate education was considerably larger for employed nurses than for BSN students. While these data indicate a dramatic decline in clinical days in psychiatric nursing, comparative analysis of time in medical/surgical, pediatrics, maternity and public health reveals similar declines. At this point there is no way to ferret out whether the decline of days in psychiatric nursing differs significantly from the decline experienced in any of the other specialties.

Up to this point we have not talked specifically about those persons who did select psychiatric nursing as their area of interest. Of course, we all would like to know if they differ in some significant way from students not interested in psychiatric nursing. In

TABLE 8

RANK ORDER OF REASONS FOR DECIDING TO ENTER GRADUATE SCHOOL: MSN STUDENTS

(N = 223)

Rank Order[a]	Reason for Deciding to Enter Graduate School
1.	More independence
2.	Other reasons
3.	Increased status
4.	Salary increase
5.	Encouragement of faculty in undergraduate programs
6.	Recommendation(s) of friend/associate/relative
7.	Presence of particular faculty
8.	Availability of tuition payback from employer
9.	Advertising/recruitment

[a] Rank order based on mean score for item in response to the question: "How important were the following in your decision to enter graduate school. Please circle one for each item." (See note to Table 4 for scale used).

TABLE 9

DAYS OF CLINICAL EXPERIENCE IN PSYCHIATRIC NURSING DURING UNDERGRADUATE EDUCATION: STUDENT NURSES AND EMPLOYED NURSES

Classification of Nurses	Number of Clinical Days in Psychiatric Nursing
BSN Student (N = 322)	16
MSN Student (N = 223)	23
General Hospital Nurses (N = 249)	26
Psychiatric Hospital Nurses (N = 171)	40

general, at least on the factors we were able to tap, psychiatric oriented students do not differ from nonpsychiatric students. They chose psychiatry because they believed it would provide opportunities for more independence, salary and status. The psychiatric oriented students chose to go to graduate school for the same reasons they cited for selecting psychiatry, and they chose their specific graduate school because of the existence of a particular clinical or functional program, the school's proximity to home, and the reputation of the school. At this point in our analysis, availability of financial aid does not stand out as a significant factor in the choice of field or in the decision to go to graduate school. However, as shown in Table 10, the majority of master's students who responded were on full financial aid. This suggests that they may not have been aware of the availability of aid when they decided to go to school or for some reason found it undesirable to report this reason as important in their decision.

TABLE 10

ATTENDANCE STATUS BY LEVEL OF FINANCIAL AID: MSN STUDENTS
(N = 223)

Financial Aid Level	Attendance Status Total (N = 218) %	 Full-time (N = 189) %	 Part-time (N = 29) %
Total	100.0	100.0	100.0
Full Tuition	70.6	80.4	6.9
Part Tuition	6.4	3.7	24.1
No Aid	22.9	15.9	69.0

To summarize findings presented thus far and a few other highlights of our preliminary analysis:

1. Psychiatric nursing does not appear to be a favorite clinical area among students.
2. Few men or minorities are involved in nursing education.
3. Students select their area of interest because they expect more in independence, status and salary.
4. Students go to graduate school for those same reasons.
5. Undergraduate students, in large part, plan to work immediately after graduation, but many are interested in graduate school at some time.
6. Negative undergraduate experience appears to be related

to lack of interest in a particular clinical field.

While these observations are interesting, it is clear that we need to be concerned with identifying similarities and differences between students and working nurses and, more importantly, to determine what specifically about undergraduate school makes it a positive or negative experience for students.

Certainly, our data identify undergraduate educational experience as an area for further investigation. Furthermore, we strongly believe that our data just begin to identify factors which may be important in interesting and recruiting nurses in the psychiatric area.

Our data do not allow us to conclude that faculty are very influential in students' decisions to go into a particular clinical area. This is of some concern in a profession which relies heavily on role modeling as an adjunct to academic experience in the process of professional education.

The paucity of blacks and other minorities and men in psychiatric nursing highlights the need for a more rigorous investigation of factors which could motivate more minority members and men to go into psychiatric nursing. It is clear that we have just begun to explore this complex problem.

UNDERGRADUATE CURRICULUM ISSUES

Elizabeth Maloney, R.N., Ed.D.

Introduction

One stated purpose of this conference is to examine selected factors impacting on the recruitment of nurses to graduate programs in psychiatric nursing.

The second purpose is to raise issues for discussion concerning the influence of the undergraduate program on such recruitment.

In a large measure, graduate programs are still dependent on attracting potential students from a variety of undergraduate programs, many of which have no similar visible graduate program component (Poulsen, 1980). That is, there are many programs in which clinical fields are so unified that the word "psychiatric" does not appear at all. These are universally called integrated programs. Since by definition, accredited baccalaureate program virtually equals integrated program, it seems useful to address the undergraduate curricula in terms of this phenomenon. From 60 to 70 percent of American nursing programs today affect this curricular style. One of the first defects to appear of course is the need to produce a generalist and a practitioner (albeit a beginning one) on the same baccalaureate foundation.

Whether the integrated curriculum directly affects recruitment to advanced study is still somewhat in the speculative realm since there are few research efforts in this realm as yet. Certainly, some leading questions with concomitant issues can be raised such as:

1. What was the genesis or origin of the integrated curriculum?
2. What do faculties think should be essential content and/or clinical experiences?
3. What are the perceived strengths and weaknesses of these programs?
4. What is the effect of these programs on recruitment into graduate psychiatric nursing programs?
5. What is the future of integration?

Development of the Integrated Curriculum in Terms of the Origin, Definition and Content

The probable beginning of this educational approach in nursing was its derivation from the larger field of education. By 1955 it was noted that there were three common patterns of organizing curriculum in the society at large:

1. Subject Matter--which has content and associated

experiences within the boundaries of organized knowledge fields; it is factual and explanatory.

2. Activity Curriculum--where the major focus is on learner action and the experiences are jointly planned by instructor and student to fill the interest and need of the student.

3. Core Patterns--The core emphasizes a social problem or issue and includes factual content and descriptive principle as well as sociomoral principle (Heidgerken, 1955:128).

These three patterns were modified, and in some instances combined, into two broad curricular patterns--the correlated curriculum and the broad fields curriculum. The correlated version is the first step towards integration but without fusion of the various pieces. An illustration here might be the use of several people to present content in the nursing care of children. A psychologist, a nutrionist and a pediatrician, for example, might assist students to cross interdisciplinary boundaries, making connections within themselves as they go. By definition it is still a correlated course because it stays within the subject matter boundaries. The broad fields curriculum pattern usually involves a process of trial and error directed toward summing up a collection of pieces from several fields and eventually reaching the goal of a unified whole (Heidgerken, 1955:129). This kind of a course needs an instructor with preparation in depth in a discipline and its related fields.

Applying the foregoing framework to the nursing area reveals the early nursing educators, in tune with the larger culture, followed a structured, logistical model. This has become the medical model, or as we sometimes say in a slightly derogatory tone, "The Big Five." This standard curriculum prevailed from 1917 to the 1937 Curriculum Guide, where the necessity to teach all the courses in such a way "that integration can readily take place in the student's mind and personality" first appeared (NLNE, Committee on Curriculum, 1937). The logistic model, or the subject-centered model, was to prevail in most schools of nursing until the 1950s or, in some cases, the 1960s and early '70s.

Why Did the Movement to Integrate Content Arise?

Once past Florence Nightingale, nurse educators began to tinker with the curriculum, primarily in an additive sense. Changing technologies, new health needs appearing as some of the old diseases were wiped out, as well as the whole knowledge explosion, made it mandatory to change curricula to keep pace. It would appear sometimes, that if nursing education errs on any side, it would be in the area of excessive tinkering. At any rate, one way in which educators have tried to deal with the knowledge explosion is to integrate the content in the nursing curriculum (Pardue, 1979). As has been pointed out by Welch and Slagle (1980:38):

> Within the nursing community, the word integration is understood as "the blending of nursing content in such a way that the parts of specialties are no longer distinguishable" (Torres, 1974).

These authors (Welch and Slagle, 1980:38) believe that "the total obliteration of the parts in order to unify the whole is an unhealthy practice. Certain nursing specialties do indeed have particular factual knowledge which is essential for proper understanding and action on the part of the nurse."

Thus, we have a mass educational movement; the revision from what one source (Pardue, 1979) calls the "blocked-content curriculum" to the "integrated-content curriculum." This has occurred largely in the last twelve years, although there were earlier integrative attempts and those who moved little from the old pattern. Whether a direct connection can be made between the advent of the integrated curriculum and a subsequent lack of attraction to the highly specialized fields such as psychiatry is still speculative at this point.

What Are Usual Patterns of Integration?

In looking at integrated and other nursing curricula it would be remiss to ignore theory and what nursing faculty elect to do with it. Conceptual and longitudinal threads abound as do key and related concepts, models and strands. Now and then it would appear that one concept is stretched or elasticized to do duty throughout an entire program. Some faculties give the impression (from the outside at least) that they have latched on to a desirable theory which they have managed to whipsaw (with varying degrees of success) into a curriculum.

On the positive side, the better efforts present a unified and virtually seamless approach. Truly integrated curricula do eliminate content overlap often occurring in the old patterns. Many of the better ones make very good sense indeed to graduates of these programs. On the other hand, nursing service people have had some reservations about the allegedly traumatic entry of these graduates into the work force. According to Jones (1979):

> Numerous nursing practitioners, nursing educators, hospital administrators and other health care professionals are presently concerned about the reported inability of many new nursing graduates to successfully make the transition from student to the realities of professional nursing unless they have had previous job experience.

It seems necessary to keep in mind that it is generally a shock to enter the work role from the student role no matter what the program. The newly employed public school teacher in an urban school, for example, has more claim to reality shock than most.

The moderately successful programs seem to have a few loose ends. These are usually tidied up by sweeping them into the nearest relevant category. The integration failures remind the observer of a trunk murderer, who, if the remains won't fit into the trunk, hastily chops off the offending bits and slams the lid down on the torso. In brief, as one source points out (Welch and Slagle, 1980:39):

> It has been the experience of some nursing faculties that integrated curricula look great on paper but do not work well in practice.

These faculties, who are usually specialists, have either a euphoric enthusiasm for integration or begin to identify problems at once. For one thing, there are numerous timing problems connecting the classroom instruction to associated theory (Moloney, 1978). Some of these linkage problems can be dealt with easily through generous and focused used of the soft and hard ware in learning laboratories. Others continue to present persistent jagged edges in the program.

A major problem, though, can be illustrated by the title and subtitle of a recent article, "Who Teaches Foundations in an Integrated Program?" subtitle: "Anxiety, Insecurity and Cultural Shock" Bach, Bell & Fernandez, 1979). These were among the reactions of faculty, expert in various clinical fields, who found themselves teaching in a basic core course. In their article, "Specialist in an Integrated Curriculum: An Odyssey," Jaffee and Flanagan (1979) say:

> Yet another area of concern has been that of our own specialist interest and education becoming watered-down in the service of baccalaureate generalist education. Some balance seems to be provided in this area by maintaining faculty specialty areas in the clinical laboratory.
>
> Working intensely on these courses has been, for us, both rewarding and painful--the pain primarily of the growing variety. Essentially we have had to re-examine both how and what we ourselves were taught. Our efforts at team teaching were initially time-consuming and frequently frustrating as faculty worked through learning to trust and relinquished the furious "protecting" of territory.

The same source commented on the nursing process as a major thread throughout the curriculum and notes that it "is taught as a tool to enable the student to assess, plan and provide care to people in diverse settings and at various points in the life cycle."

The value of nursing process, which is essentially problem solving in the service of the application of a body of knowledge to the problems of a varied client system, is that it is the core of any true professional practice. One is simply grateful that as a part of the integration effort, we have at last agreed on something akin to the social worker's case work to unite around.

The Integration of Psychiatric Nursing Concepts into the Curriculum

It was the 1950s which saw a massive National Institutes of Mental Health funded effort to bring the mental health psychiatric concepts into the total curriculum--to integrate them as it was said, then, into all of the areas of nursing. Persons to integrate the faculty were hired as well as persons to integrate with students. The faculty of other areas who wanted no part of it went underground, crying that genuine integration takes place in the student. It was, in sum, the best and worst of times and psychiatric faculty participation was in high demand. Sometime in the early 1970s the last of the funded projects were ended and disappeared from the scene. What they left behind was a different order of things in which a new generation of faculty would have thought it uncivilized not to include many of the psychiatric concepts in everything taught. It is thought however, that some faculty confuse these more general mental health psychiatric concepts with the psychiatric concepts...or they say they are integrating them, but they are difficult to locate, at least in any real depth.

Perhaps it can be said that we in psychiatric nursing sold our snake oil too well since one of the residuals of that era is an emphatic inclusion of behavioral concepts, sometimes with only a passing bow to the nursing care of disturbed psychiatric patients.

It is my impression also, that some of the graduate programs in psychiatric nursing have drifted into more psychosocial content than the large contingent of psychiatric patients awaiting care would find useful.

It could be speculated then, that two things have occurred in some degree or other in (perhaps) too many places:

1. Courses have focussed on behavioral concepts, integrated throughout the undergraduate curricula, with many programs skimping on the psychiatric content so necessary for care to the large group of the mentally ill in this country. It is difficult to choose a field for graduate study if there has been little or no exposure to it in undergraduate programs.

2. Faculty who are responsible for teaching in these programs did not themselves experience graduate programs where rigorous attention to depth content took place. If there is no challenge in the contemplation of an abstract, disciplined framework unfolding in tandem with focused, connected and well-supervised clinical work, then the best people will not be attracted to teaching. In turn they cannot

encourage students.

People from the undergraduate programs have always been backwards about entering psychiatric nursing. Whenever the area has been under scrutiny as a career, the old influences still weigh heavily--cultural factors, poor undergraduate experiences, certain norms of postgraduate employment and the persistence of what appears to be a strong need to get experience before going into psychiatric nursing. Actually, students inform me it is a testing out, an incorporation of all that they have learned during an educational program. They also note that it is a time of coming to terms with many other life factors before they can think about psychiatric work. Perhaps the continuing education programs of the general hospital would be a more rewarding field to harvest for candidates.

All of the foregoing being valid, there is still a suspicion that a large number of persons who are considered under the rubric of psychiatric patient are not really considered to be genuine patients by a lot of nurses. It must also be noticed that there is a gap between the health/prevention oriented baccalaureate program and where its graduates elect to work. The chronically ill, the mentally ill, the nursing home, require a different viewpoint. If the health needs of our country are to be met, probably one of two things has to happen:

1. A large number of people entering the professional arenas of the health field have to learn to deal with people who are defined as ill that they are not dealing with now in any substantial numbers.

2. Or, the kinds of people entering the field will have to change--so that dealing with deferred or delayed satisfaction and ambiguity becomes possible--or recruitment from a different population with different professional goals occurs.

Brief Summary

There are some signs that the early, uncritical enthusiasm for the integrated curriculum is being tempered with realism, which might be germane to the concerns of this group (Welch and Slagle, 1980; Veith, 1978; Styles, 1976). It was predicted in 1971 (Stevens) that there might be a partial move to return to the logistic mode of curriculum building. In one undergraduate program a middle-of-the-road approach has been developed, described as "somewhere between integrated and logistic design, so that we can use the best aspects of each in revising curriculum" (Veith, 1978).

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PSYCHIATRIC MENTAL HEALTH NURSING IN THE UNDERGRADUATE CURRICULUM

Recommendations:

I. Basic nursing programs must include theoretical and clinical learning experience in Psychiatric Mental Health Nursing. Such courses must be developed and taught by prepared psychiatric nurses.

II. Psychiatric Mental Health Nursing faculty should be clinical specialists in psychiatric nursing with knowledge of curriculum, teaching, methodology, and evaluation.

III. Psychosocial concepts should be integrated into the curriculum and should be monitored by faculty prepared in Psychiatric Mental Health Nursing.

IV. Schools should attend seriously to development of performance-based methods to evaluate students' abilities in psychiatric nursing.

V. Faculty should be encouraged to advance their own practice competence through such activities as demonstration projects, clinical research, and joint appointments.

VI. Psychiatric nurse researchers should serve on national or regional advisory committees to review intra/extra mural research in the psychiatric mental health field.

VII. Psychiatric Mental Health Nursing faculty must take an active role in the recruitment of students.

VIII. New graduates who are interested should be encouraged to directly seek employment or advanced education in Psychiatric Mental Health Nursing.

VALUE OF MASTER'S LEVEL NURSES IN THE FIELD

Ruth Lewis, M.S.N.

The primary concern of any profession is the service it offers society through the practice of that profession. Nurses are committed to the improvement of health care for all people.

We speak to:

--responsibility for educational preparation of nurses who are competent to practice

--need for continued professional development

--formulation of policies and plans for health care in collaboration with others

--emergent needs for health care and nursing care in the future

--spirit of inquiry and evaluation of the outcome of the services we have provided.

We are concerned with:

--accessibility to health services offered by nurses

--cost effectiveness of services we render

--responses to unmet health care needs of people of different cultural and economic backgrounds.

A nurse considering entering into a master's program in nursing may ask:

--will I think better about myself professionally if I have a master's degree in nursing?

--will the graduate degree help me to get a job?

--will I be compensated financially at a level comparable to others with the same level of educational preparation?

--will I impact professionally in my area of practice?

--will I be accepted by my colleagues? other nurses? other professionals?

--will I be recognized and identified as a specialist in my field?

Graduate programs in nursing provide the opportunity for study in areas such as administration, teaching, consultation, research, and clinical practice. These graduate programs in nursing also provide a strong educational base for post-master's and doctoral study.

Within the past ten years, the whole spectrum of nursing education has moved forward. Where once most faculty in baccalaureate nursing programs were prepared at the master's level, the demand now is for doctorally-prepared nurses. Involvement in nursing research is focused on doctorally-prepared nurses. Clinical practice in a specialty area demands a more scholarly preparation for nurses. Increasingly complex preventive, therapeutic, restorative, and rehabilitative modalities, as well as the changing roles of other health professionals, require that the nurse practicing in a specialty area be prepared at the master's level. Entry level into nursing is at the baccalaureate level.

The definition or meaning of nursing has not changed. It refers to the diagnosis and treatment of human responses to actual or potential health problems.

Nursing is practiced by nurses who are generalists and by nurses who are specialists.

> Generalists in nursing have a comprehensive approach to health care and can meet diversified health concerns of individuals, families, communities.
>
> They provide most of the care for most of the people and are prepared in baccalaureate programs or AD or diploma programs.
>
> It is generally acknowledged that most nursing practice is general nursing in a specialized area which has a specialized population or focus.
>
> Specialists in nursing are experts in providing care focused on specific phenomena of concerns. Specialized nursing practice represents a refining of interests, either by focusing upon a part of the whole of nursing practice or by focusing upon relationships among the parts.
>
> Specialists in nursing practice have autonomy and freedom in practice. Their expert knowledge is associated with greater self-discipline and responsibility for direct patient care. Specialists are prepared in graduate programs.
>
> The Specialist in psychiatric and mental health nursing can be expected to:
>
> --predict behavior of clients
>
> --identify probable nursing care problems
>
> --develop a plan of action (including creative approaches to solutions to problems)

--assume practice roles in the mental health delivery system.

The practice setting can expect the P.M.H. Nurse Specialist to:

--identify populations at risk

--direct care of selected patients or clients

--role model in a variety of settings

--provide intraprofessional consultation to Nurse Specialists in different clinical areas

--provide interprofessional consultation and collaboration in planning total patient care for individuals or groups of patients

--plan and evaluate health programs for population groups at risk

--be a nurse specialist who is prepared to practice nursing in a variety of settings.

The need is imperative to relate education closely to actual functioning in various kinds and levels of practice roles. Approaches to care and the actual delivery of mental health services may be different in various settings. The delivery of nursing services in a free-standing clinic may be vastly different from those delivered in a large state hospital, a community mental health center, or the psychiatric unit of a general hospital.

Many issues impact on the value of a master's-prepared nurse to the mental health field. There are some who would argue that a graduate level degree is not necessary for a nurse to practice. They are the defenders of antiquity.

There are those who would argue that nurses prepared on a master's level should be able to provide health care services to patients whatever their disabilities and in whatever setting the patient resides. They are the defenders of master's programs which prepare generalists to function equally well in all settings.

There are those who have practiced in specialty areas who have little difficulty defending the need for graduate level programs in nursing focused on the care of specific populations in specific settings.

The nurse prepared at the master's level in mental health has much to contribute to the field; not only as a specialist in the clinical practice of mental health nursing, but as a role model, as a specialist in a practice setting, as a peer among other disciplines, as a consultant to other nurses and as a leader in her field.

THE VALUE OF MASTER'S LEVEL NURSING IN THE PSYCHIATRIC MENTAL HEALTH FIELD

Recommendations:

I. Because of the major decline in enrollments in the past 10 years: NIMH should publicly recognize Psychiatric Mental Health Nursing as a critical shortage area and establish psychiatric nursing education as the highest priority area for funding of clinical training.

II. With respect to graduate preparation of MSN's in Psychiatric Mental Health Nursing, the quality and quantity of clinical supervision is critical.

We urge that:

1. Practice in the graduate programs be specialized, not generalized;

2. Supervised clinical practice be a significant component of graduate study;

3. Psychiatric nursing educators be role models in the field agencies where students practice; and

4. The student be placed in agencies where psychiatric mental health nurse specialists practice.

III. With respect to curriculum, we urge that:

1. Nursing undergraduates have a specifically designated Psychiatric Mental Health Nursing experience with specialty prepared faculty and in settings where specialty role models practice.

2. Graduate programs in Psychiatric Mental Health Nursing include theory and clinical practice related to acute and chronic mental illness.

IV. With respect to funding for psychiatric nursing education, we urge organized and cohesive lobbying on behalf of Psychiatric Mental Health Nursing by the AACN, NLN Council of Baccalaureate and Higher Degree Programs, the ANA Division on PMH Nursing Practice, The Chief Nurses of the Veterans Administration and the Armed Forces, and the National Council of Psychiatric Mental Health Nursing Program Directors.

V. With respect to utilization of psychiatric nurse clinical specialists, we urge that NIMH set aside research funds for demonstration projects to explore the cost effectiveness and impact on quality of care of these specialists in different settings.

VI. We recommend that ANA maintain identifiable nurse practice structural units and take a strong lobbying position on behalf of Psychiatric Mental Health Nursing.

VII. With respect to utilization of Psychiatric Mental Health Clinical specialists, we urge that state personnel classification systems be modified to include clinical nurse specialist classifications with salaries competitive with private nonprofit and private settings.

MINORITY ISSUES

E. Lorraine Baugh, R.N., M.S.N.

What's wrong with this picture? A child dreams of being the latest superhero. What could be wrong with that? Plenty, if the child is Black and can't even imagine a hero the same color he or she is. Children learn by what they see. With the few number of Black nurses in this country, it is no wonder that a Black child cannot see the world as it is, with Black men and women doing positive things besides playing basketball and singing.

Majority America must use this picture to understand just how serious and basic the problem really is. We have to be about providing Black children with a real picture of what is possible. This will only be possible when majority America stops pussy-footing around with the words "reverse discrimination" and gets on with the business of equalizing opportunities, of making up for past inequities. Unless and until this is done, we will continue to have children who can't imagine a hero the same color he or she is or more to the point, imagine a nurse the color he or she is.

The National League for Nursing (1979) published a Position Statement which called for "the removal of all legal and social barriers that deprive racial minority groups of opportunities essential to their full participation in our society." The NLN further stated that "nursing educators should continue to focus particular attention on minorities and the disadvantaged to assure that these members of our society are not subjected to discrimination." In their guidelines for implementation of nursing education programs, it was stated that continued emphasis should be placed on:

1. Recruitment of minorities in the development of remedial programs.
2. Introduction of variable admissions criteria.
3. Support services to enhance retention.
4. Culturally diverse curriculum.
5. Continuing education programs for the faculty which would foster a broadened understanding of working with a multiracial society.

In this statement, two timeworn phrases are used: recruitment and retention. For the sake of making a point, I'm going to use an extreme example and suggest that there is a conflict when using the terms recruitment and retention together as if one automatically follows the other. One definition of recruitment is "a fresh supply of something." One definition of retention is "the state of being retained or being kept." The first suggests an unknown quantity--a fresh supply of something--that something being unknown. For many people, reaction to the unknown is fear, mistrust, apprehension, hesitation or insecurity. Couple this reaction to the unknown with the concept of retention and you can readily see why the two terms don't go hand in glove. After all, who is going to try to retain individuals if they are afraid, mistrusting, and apprehensive of, or insecure around, that someone or something. Ask yourself the question: Would you retain something if you were afraid of it, or apprehensive about it, because you didn't know about it?

While I have used this example as an extreme, think about the problems that both students and faculty have when one group, the student, is trying to achieve the unknown and the other group, the faculty, is trying to help them achieve it. The student fears initial failure and the fear that continued failure engenders. The faculty fear their abilities as teachers will be questioned if the student fails. You can see that this is the beginning of a vicious cycle.

But let me get into more specifics regarding problems of recruitment and retention of minority students. None of what I'm about to say is new. However, it troubles me that we are still talking about the same issues which were identified fifteen years ago. The number of Blacks entering and completing nursing programs today is decreasing rather than increasing--a troubling statistic.

I firmly believe in what Johann Heinrich Pestalozzi said, "people will never hesitate to let you help them if you but know how to go about it; for anyone will gladly climb the ladder if he but sees that he can scale it safely."

In my opinion, just about any student can survive if given appropriate help. "Educationally inexperienced" students lack only the skills (credentials) but not the qualities to succeed. They demonstrate the necessary plus factors such as: motivation, creativity, resilience, leadership, or some other "X" factor which translates into strength. These students know they can do the work if given a chance. To open the door and give these students a chance requires more than just turning the knob. It requires accepting the challenge to the following issues which can no longer be swept under the rug. These issues are considered barriers--barriers to minority students' admission, successful participation and graduation from nursing programs. These barriers represent a complex series of factors which involved the prevailing educational, cultural and social systems in a particular geographic area and in the Nation as a whole. Five categories of barriers broad in scope have been identified. One must understand the barriers and how they relate to each other in forming a most formidable obstacle. Therefore, if there is to be a significant reduction in, or an elimination of, these barriers, each barrier must be identified and dealt with adequately and responsibly.

Barriers

I. Educational Deprivation--Those students with an inadequate or inappropriate secondary school education have had their foundation laid for such problems as inability to read, understand, or communicate well in their own language; the inability to think quantitatively; a poor foundation in the sciences; and poor and/or biased career counseling.

A. Poor Academic Preparation--Poor academic preparation produces "educationally inexperienced" students who have not mastered a series of synapses or steps in the learning process. This can be translated into a variety of barriers to learning.

B. Academic Achievement/Aptitude Tests--In exploring the question of tests, it has been found that few tests are useful in screening the minority candidate; not even the nonverbal or matrices tests or so-called "culture free" tests. Basically tests show how well, in comparison with peers, the testee has absorbed his culture and education. Testing individuals who have not had the advantage of an adequate or appropriate education merely proves that they lack basic skills and in no way tests their aptitude or academic potential. Yet Stanley (1971) concludes after reviewing the literature that "admissions to selective colleges should be based substantially on test scores and high school grades whether or not the applicant is from a minority racial, ethnic, or socio-economic group."

Review of research on ethnic variables in the educational process bears out the fact that membership in a particular racial-ethnic group has no effect on academic achievement when adequate controls for socio-economic factors are employed. In a national survey, 24 percent of the differences in academic achievement was associated with membership in racial-ethnic groups of Indian, Mexican, Puerto Rican, Negro, Oriental or White. After socially conditioned variables were accounted for, the 24 percent dropped to 1.2 percent (Pedersen, 1972).

C. Career/Academic Counseling--Poor and/or biased counseling frequently accounts for students' lack of awareness of educational opportunities and career mobility in the nursing field.

Vontress (1968) feels it is the duty of the counselor to inform college admissions offices of the strength of Black students despite modest test scores. He also cites certain factors as inhibiting effectiveness of a counselor when working with Black students: ignorance of students' social-psychological backgrounds, language barriers(which applies to minorities in their mode of expression), and minority students' unfamiliarity with the concept of professional counseling.

An analysis of these barriers clearly indicates that "educationally inexperienced" students have been consistently pushed farther away from the mainstream of American society. Adaptive skills that enable a student to function in a higher educational setting are usually acquired early in life, in the environment of family, peers, and school. But the family and school situations have not always functioned for the minority and/or "educationally inexperienced" students as they have for the majority educationally experienced students. In other words, these students have not been provided with the adaptive and functional skills necessary to make it possible for them to enter postsecondary programs.

II. Cross-Cultural Interpersonal Communications--The more overlap in life experience, the easier it is for two individuals to communicate on an interpersonal basis. Communication becomes increasingly more difficult when persons from two different ethnic groups are involved or when the frames of reference used are worlds apart. A breakdown in communication produces barriers such as alienation and isolation. Language itself can be a barrier. The language in which any message is delivered is as important as the message itself. A person speaking in a foreign language, "ghetto" language and/or dialectical patois communicates to the receiver something else besides the spoken word.

A. Language

1. Foreign--Foreign-born students, or persons who use English as a second language, regardless of the number of years they have lived or were educated in the United States, will have great difficulty in expressing themselves in verbal and written English. This is further complicated by their unfamiliarity in expressing themselves in our idiomatic usage of the language. These students must often translate from English into their own language, interpret the data received, retranslate into English and only then record the information. This process takes so long that note taking and test taking become interminable, tedious chores in which the lack of adequate language skills spell the difference between success and failure (Baugh, 1971).

2. Dialectical Variations or Use of Language not Representative of School Environment ("Ghetto Language"; "Different Language")--such factors as pronunciation, variations in vocabulary, idiomatic expression, etc., may severely penalize the students in their attempts to acquire concepts embodied in the curriculum. Students will be understood by their peers and parents but not necessarily by their teachers. Use of ghetto language is often equated with saying that individuals cannot communicate, particularly those individuals who have been labeled disadvantaged, and who, for the most part, reside in ghettos, barrios, slums,

depressed areas, migrant camps and reservations. A further misconception is that whatever the language being used, it is unintelligible and cannot be understood. Certainly, many people labeled as disadvantaged do not talk the way the majority of Americans do. However, "disadvantaged or different" individuals can communicate. "What is often misunderstood is that verbal expressions are a somewhat sophisticated means of excluding outsiders, and that in practical knowledge they are far from inferior." Their language differs and is therefore unacceptable to the average American because the "disadvantaged" form a separate community within American Society, separated and isolated from "normal society" geographically by location, and psychologically by attitudes and behavioral patterns; if they are Blacks or Spanish Surnames, by their color (Carbine, 1969).

B. Cultural Differences, Alienation and Isolation--Cultural differences do exist. Most recognize those who look different, talk different, dress different, and eat different from them. The degree to which the various cultural differences in American Society are understood and accepted, as opposed to merely being tolerated, is indeed very limited. Much has been written on these very familiar cultural differences. However, not much has been written or understood about the culture of poverty. Many of the "disadvantaged," "educationally inexperienced" students are products of a culture of poverty. The lack of understanding of this phenomenon may often lead to alienation and isolation of students. These students will encounter additional difficulties which will cause their adjustment to school to take longer and thereby hinder their academic success. Specifically, their adjustment to the white, middle class school may involve fear of not being accepted; embarrassment over lack of appropriate clothing or sufficient money; awareness of lack of formal education within their families; the insecurity of not knowing what is expected of them or what to expect from others; differences in perception; the double standard that forces them to prove themselves because they are different from the dominant group; the often hostile, condescending or patronizing attitudes encountered by the nonwhite in an all-white environment (Baugh, 1979).

"The culture of poverty"is not just a matter of deprivation of organization, a term signifying the absence of something. It is a culture in the traditional sense in that it provides human beings with a design for living with a ready-made set of solutions for human problems and so serves a significant adaptive function. This style of life transcends national boundaries and regional and rural-urban differences within nations. Whereever it occurs its practitioners exhibit remarkable similarities in the structure of their families, in interpersonal relations, and in their orientation in time" (Daniel, 1971). It is no wonder then that middle-class assumptions about common sense and social responsibility have no meaning to students from this culture. This serves only to further isolate and alienate them from the dominant school culture. Nobody has taught them to make provisions for or allowed time for them to make the necessary and timely adaptations to ensure survival in a highly complex and competitive social order. Or even more significant, no provisions have been made to accept them and their differences because these differences do not mesh with the expectations of the system as it is currently designed and defined.

C. Attitude, Self-Perception, Motivation--Attitudes are personal and the basis of prejudice. The individual builds his attitudes as he lives and learns in his environment. Attitudes become habit patterns. Attitudes resulting from different lifestyles will influence an individual's view about education, academic achievement, motivation, self-concept and willingness to seek and accept help.

Behavioral and social sciences have legitimatized and perpetuated numerous societal myths concerning minorities. The prevailing belief of many social scientists and public school teachers that Blacks are not educable by virtue of their genes has served as a self-fulfilling prophecy for many Blacks. The increasing publicity given to the problem of massive and cumulative retardation of Black children compared with Whites makes many Black students afraid to compete. A Navajo student's apparent lack of motivation or interest in high academic achievement may be misinterpreted by educators who are not familiar with the Navajo's attitude toward competition. "The Navajo culture does not encourage individual achievement at the expense of their fellow man" (Peterson, 1971).

In a study completed by Kaplan (1969), there was a "significant positive relationship between self concept and academic achievement. That is, those children having more positive self concepts had higher academic achievement." Thus an apparent drop in motivation of a previously motivated "culturally deprived," "educationally inexperienced" student may be attributed to many factors. These factors may be internal or external; however, many external factors increase or decrease a student's perception of himself and thus his motivation. The communications barrier is not insurmountable if persons attempting to communicate appreciate the realities of the situation and the capabilities of the people with whom they are dealing.

III. Socio-economic--Several issues are of importance in this category: family structure, financial status, socialization and environment.

  A. Family Structure--Family structure varies in different lifestyles. Indians have an extended family structure, which may place several demands on its members (even though they may be in school), that are not accepted nor understood by those outside of this culture. Some groups have no stable family structure.

  B. Financial Status--Financial status varies significantly. With limited financial resources, meeting immediate needs is of utmost importance. If there has never been a savings account or extra money, individuals may never learn to budget. Demands may be placed on students' financial resources by their families, friends, and by educational institutions. Because of this, most minority students have worked long hours while going to school. They think that working and going to school is a way of life not to be separated. Most are working not just for extra pocket money but to put additional and necessary money into household budgets. The demands postsecondary education placed on students, especially those with poor academic preparation, will not allow students to continue to do both. If they do, the results will be reflected in their academic standings. Yet for many students not working means not being able to attend school.

  C. Socialization--The socialization process, learning how to manipulate and survive the system, is often overwhelming, and many times defeats the ablest students. In addition to maintaining a full academic courseload, learning how to study, take notes and tests, minority students must also adjust to White students, White professors and White social customs and norms. Many fears can be generated during this acculturation process. The fear of initial failure, and the fear that continued failure engenders, fear of being overpowered by teachers who are ignorant of the culture and mores of their society, fear of being misinterpreted, fear of lack of understanding from teachers whose backgrounds are totally dissimilar to theirs, and fear that their efforts to achieve and accommodate to demands which are basically alien to them will go unrecognized.

  D. Environment--The environment of which we are a product may color minority students' perceptions of the world they are entering. Since they have not been members of the mainstream society, their actions, interactions, and reactions to what they see may cause increasing problems for them and for others.

IV. Recruitment/Admissions, Financial Aid

A. Recruitment/Admissions--Subsequent to the death of Martin Luther King, there was a surge by traditionally white institutions to increase their minority representation. Giving further impetus to this effort was pressure, from the Office of Civil Rights, DHEW, on the institutions to comply with the 1964 Civil Rights Act. In spite of this apparently well-intentioned and committed effort, the traditionally white institutions are still educating only 3 percent of the Black population pursuing higher education.

The majority of the allied health programs are conducted in traditionally white institutions. If, as reflected in the 1969 national survey, the entering freshman rate continues at the 3 percent level, there will never be a substantial increase in minority representation in the allied health programs unless the traditionally Black institutions are given substantial assistance in establishing health programs in their schools.

While many institutions have established "special programs" for the so-called "high risk," "disadvantaged," "culturally deprived" Black students, the admissions procedures used for these programs and for regular Black admissions remain very traditional (Sedlacek, 1970). Standardized tests and high school grades are widely used while extracurricular activities, recommendations, interest, motivation, initiative, and seriousness of purpose, which may be more accurate predictors of academic potential, are used relatively infrequently.

Colleges have created these special programs for minority students largely because they really believe that all Blacks, Indians, Puerto Ricans and Chicanos are disadvantaged and therefore need tutoring. In 1970, 62 percent of all Blacks enrolled in public colleges in New York State were put into so-called "Opportunity Programs" (Meyers, 1972).

Not all recruitment efforts have been so blatantly racist. Sincere efforts have been made by many institutions which are deeply committed to bringing about a change in the nature of American Society. Many programs have recognized the fundamental problems facing many minority students and have begun to implement programs to rectify these. Some identify potential minority students early in secondary school education and provide them with role models to emulate and tutors to assist them in bringing up their academic grades along with improving their understanding of the course content. Much effort has also been placed on convincing minority students that they do have a chance to get admitted to a career that heretofore has been beyond their reach.

B. Financial Aid--Recruitment in the present economic climate also poses barriers. The cost of nursing education has been an obstacle to many students who might have chosen this field. The legislation in the health field that provided for loans and scholarships has been drastically cut and the competition for these fewer dollars has increased.

The ability of many students to cope with the university or college environment is highly dependent upon their financial aid situations. Students not having pocket money or a wardrobe that an active college life dictates will have a sense of insecurity. "Insecurity breeds discontent and interferes with motivation. Without motivation, the chances of realizing goals are seriously stifled" (McClellan, 1970).

V. Institutions and Faculty--Ronald Goldman (1968), as a postscript to a collection of essays written by persons of disadvantaged background who have succeeded, stated "...but one is impelled to ask the question whether in fact we have as yet achieved free, universal educational opportunities for all in such a way that those who have come from stunted backgrounds are given the fullest opportunity to succeed? These essays I trust will show quite convincingly, although not in a statistical manner, that equality of educational opportunity can never be realized until the worst elements of social inequality are removed."

A. Institutions--The successful completion of a program depends for the most part upon institutional commitment. This means that recruitment, admissions, and retention of minority students must be approached from the perspective of a total organization geared to give full support to the student from the moment of initial contact through graduation. It is crucial for the assistance given a minority student not to end when he/she is admitted to a nursing program but be sustained throughout his/her educational experience to meet his/her academic and emotional needs (Baugh, 1971).

B. Faculty--After students have been admitted, the responsibility for their retention fall on the faculty. Its cooperation may mean the difference between their success or failure. While academic support is essential, emotional and psychological support must also be provided. Barriers are encountered here when the faculty is unable, unwilling, or does not know how, to become involved in making an effort to reduce the above barriers.

The key to successful development and implementation lies in the recognition of the problems confronting individuals from disadvantaged backgrounds, together with the realization that these problems are so complex, that any attempts at solutions require a multi-faceted approach involving the educational institutions, faculties and students. This three-pronged approach is an effort to deal with the obvious fragmentation of the sixties and seventies where the problems of access, success and completion were viewed as either a student problem or a faculty problem. It is clear from the statistics in the literature and from the barriers outlined here, that the problems still remain. Little or no attention has been given to the need to develop an approach which would bring together the collective individual experiences gathered over the past several years in the sixties and seventies, to provide linkage among those affected by the problems of inadequate representation of Blacks and minorities in the nursing profession. To address the problems, a three-pronged approach--students, faculty, and institutions in a coordinated effort--is needed. The following should then be the results:

1. the student will be recruited, retained, graduated and pass the state board examination and thus increase the number of Blacks entering the nursing profession.

2. the faculty will understand the needs of the student, work successfully with the student and obtain a great job satisfaction from seeing the positive results of their actions, and

3. the institutionswill have better utilization of their resources, admit better prepared students and fulfill their responsibility and commitment to the larger community.

Many times faculty are placed in untenable positions in their quest to maintain high academic standards and quality control. Many factors influence the retention rate of students. Faculty have varying degrees of control over some of these factors. Others present monumental problems for the faculty and the students. Some of these factors are:

The Faculty

1. Attitude which faculty have towards students who are different from them and the fear that their standards would be lowered if any concessions are made to these students.

2. Availability of supportive services.

3. Patronizing or making undue concessions to accommodate the different student.

4. Levels of expectation on the part of the faculty--some of whom appear to be setting the student up for failure.

5. Faculty feeling pressure from administration to accept more and more Black and minority students.

6. Faculty reacting against what they view as accusations against them with regard to:

    a. their lack of understanding.
    b. their unwillingness to be of service.
    c. being racist.
    d. the inappropriate and exorbitant demands made on their time.

7. Multiple standards regarding grading.

8. Instructor defensiveness.

9. Destructive use of power that is vested in the teachers.

10. Peer support in case of justified or unjustified challenges.

11. Instructor anticipates failure and is waiting to see it to justify a grade that has been predetermined.

12. Counseling and/or coaching of students.

There are equally as many factors that if instituted by the faculty will assist in increasing the retention rate among poor, Black and minority students.

1. Set the standards.

2. Let the student know what these are and that they will be adhered to.

3. Inform student about the assistance and help you can give to him/her or what is available from other sources.

4. Evaluate the student on only those areas which are pertinent to what has been taught in the course or expected from the student.

In setting the standards, let students know what is expected of them and what they may expect from you. The faculty should determine and make students award of the content, skills, and competencies they must have in order to succeed in a nursing curriculum. Competencies should be stated in behaviorally objective terms so that it is clear to students that the behavior expected of them and upon which they will be evaluated is based on skills, theories or values. If values are being judged, care should be taken to insure that they are values relevant and universal within the profession and do not represent personal values of the instructor. Faculty should provide a meaningful, successful, learning experience in which there is recognizable achievement perceived by students and rewarded by the instructor.

Students

Certainly, if the institution and faculty are against them and do nothing to help students, the chances for retention are dim. However, the chances for success are nonexistent if students have not clearly looked at and identified the following in terms of their characters and development:

1. Interest in nursing.
2. Educational background.
3. Perception of available opportunities.
4. Level of aspiration.
5. Self-concept.
6. Degree of control they feel they have over their own future.
7. Perception of self in relation to others, especially members of other racial groups.

Student may possess the above assets to an extraordinary degree and still have problems in making it in the school if:

1. The type of curriculum and level of course in high school did not prepare them to adequately handle postsecondary school curricula;
2. Their performances on standardized tests are poor;
3. Their financial situation require them to work more than is advisable;
4. They are unwilling to accept aid in obtaining adequate preparation for admission to a school;
5. They are unable to recognize that their difficulty can't be overcome on their own;
6. They are unable to ask for help even after they have failed courses;
7. They have poor attendance records at tutorial sessions.

The successful retention of the poor, Black and minority students in the current system, is based on an environment that brings together competent teachers, effective instructional technology, and materials that are relevant to the needs and interest of students. Within this context, the educational environment must enhance motivation for success by augmenting the student's self-esteem and aspirations for achievement which emanate in large part from pride in **students'** background.

A QUESTION OF RETENTION

1. What blocks communication?

2. What facilitates communication?

3. What are your feelings about students who do poorly or fail?

4. Why are special programs associated with Blacks or other minority groups less acceptable to the faculty, admissions, and financial aid personnel than special programs for athletes or foreign students?

5. How do faculty and "risk" or "special" or "different" students perceive each other?

6. How do age, educational, cultural background influence perceptions?

7. Why might a "risk" student refuse or be reluctant to ask for help?

8. What is the effect of "bending the rules" for "risk" students?

9. What conditions are necessary for a student to succeed in a school of nursing?

10. Why are minority students recruited? What is the effect of this recruitment and the reason for it? Is this really an opportunity for the student?

11. Are the criteria used to evaluate clinical performance relevant? What is the effect of bringing extraneous or irrelevant factors into the evaluation process?

12. What is the responsibility of the faculty of a school of nursing for ensuring that the conditions necessary for successful clinical experience exist in the agencies so used?

13. What is the effect of the self-concept of the faculty? Do they see the "different" student as valid or invalid reflections of self as professional?

14. What is the meaning of work in the life of a socially and economically disadvantaged person? What are the implications of this for the way a student may use work?

15. How could and would you confront a co-worker about his or her demonstrations of prejudice?

16. How do you reconcile the rhetoric about the values of the profession with the individual's performance?

17. What is your attitude toward students who come to see you without an appointment?

18. What is your attitude toward the Afro-American groups on your campus? How do you work with them?

A QUESTION OF CLINICAL SKILLS

1. What is it that nursing students need to know while they are in the clinical area?

2. What criteria are being used for clinical evaluation?

3. Are these criteria based on skills? Theories? Values?

4. Are values which are used all relevant to nursing?

5. What is the extraneous information being used in evaluations? Once it is recognized how do we deal with it?

6. If we recognize extraneous information is being used, then we must change it if we subscribe to the philosophy of nursing, which is the rights of the individual.

7. How can we give the most helpful evaluations and not violate the basic right of the individual to be him or herself?

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MINORITY ISSUES

Recommendations:

I. Recruitment of minorities: Schools of nursing should use a systems approach in the recruitment of minority students which includes attention to:

1. Faculty

   A. Minority student advisement should be an integral part of faculty responsibilities and faculty providing this advisement should be credited for time spent in this activity.

   B. Faculty should be appropriately prepared for work with minority students and minority health care consumers.

2. Students

   A. A support system must be provided for minority students, including both social support and tutorial help.

   B. Minority students should also be encouraged to accept responsibility for their own success.

3. Institution

   A. Colleges and universities must reexamine admissions policies which limit enrollment of minorities.

   B. Colleges and universities must reexamine the use of existing learning resource centers to meet the special needs of both nursing and minority groups.

   C. Preparatory education for minority students must be provided.

   D. Colleges and universities should develop centers for minority recruitment and retention.

4. Community

   A. The university and minority nurses in the community should work collaboratively to recruit minority nursing students.

   B. Guidance counsellors in high schools should be advised of and involved in efforts to recruit minority nursing students.

II. Graduate Education in Psychiatric Mental Health Nursing

All graduate programs in Psychiatric Mental Health Nursing must prepare nurses to address the special needs of the minority communities with which they work.

III. Program Funding

Implementation of recommendations I and II should be considered in decisions on funding of nursing education programs.

IV. Research

Research proposals submitted to NIMH which address special problems of minorities should be given funding priority.

V. Task Force

The Black Nurses Association, in cooperation with other minority nursing associations, should convene a national meeting of ethnic nurses of color to address recruitment and retention of minority nursing students.

MARKETING PROBLEMS AND STRATEGIES

Diane McGivern, R.N., Ph.D., F.A.A.N.

Although marketing is a field well known to us as consumers, marketing as a professional endeavor is less familiar to us as professionals. Marketing is generally defined as developing an interest in and demand for a certain product or products. In our discussion the product we are promoting is nursing and particularly, the one specialty, psychiatric mental health nursing. Another perspective in this discussion will also include as our product the master's prepared psychiatric nurse clinician whose role we are selling to the appropriate agencies.

Until recently marketing and recuitment strategies have not been identified as necessary or even desirable in nursing education and practice settings for several reasons including: 1) a lack of stimulation and 2) lack of a certain degree of sophistication regarding marketing techniques. The current stimulation to investigate, employ and measure marketing techniques and strategies arises from the current imbalance in supply and demand for nurses of all specialty preparations and particularly for psychiatric mental health specialists. The fact that we are recognizing the need for such an entrepenurial approach prompts a question for the next phase of this effort: if we do address this problem will we continue the marketing and recruitment effort over a sufficiently long period of time to ensure immediate and long term results?

Professional nursing has been very much preoccupied with the upgrading of the preparation programs for practice and establishing and effecting the scope of practice. The need to promote the idea of nursing as a profession and garnering prospective nurses was not a priority and was not, and still is not, considered an effort worthy of a profession. Current need forces us to investigate marketing applied to nursing and ponder whether we will have to pursue this further in the future, directing our new skills to the issue of whether society needs nursing as we know it.

Need

We are all familiar with reasons or factors which have contributed to our concern for the future ranks of practitioners. Declining interest in nursing as a career and the selection of psychiatric mental health nursing as a practice area may be due to:

1. A change in national values which relegates service to others to an obscure place on the list of national and individual priorities. This seems to be particularly true when the "others" are very different or highly selected populations.

2. General disregard for, or devaluing of, professions and professional status. The limited number of occupational

groups who traditionally received special respect has been markedly expanded. Now high level business executives, technicians involved in new and esoteric fields, politicians and others whose salary and capabilities compete, share the mystique formerly surrounding physicians, ministers, lawyers, nurses and engineers.

3. Feminism, for all its benefits, may have exacerbated the stereotype of nurse as passive, secondary and intellectually mediocre.

4. Discrepancy between nurses' wages and those of comparable professional groups. The economic disincentive and resultant shortage of nurses in institutions is compounded by the increased intensity of care in hospitals and the expansion of those populations who require more care hours.

Deterrents

Since we are all acutely aware of the need to attract highly capable individuals into nursing and further to promote psychiatric mental health nursing as a practice option, what factors make marketing and recruitment techniques difficult to promote? Several reasons suggest themselves:

1. Lack of exposure to these strategies except in the most oblique manner--as consumers responding to commercial efforts.

2. Nursing's "purity of values" which excludes "selling." We question the ethics of manipulating images and consumer perceptions in order for prospective nurses or employing health agencies to make certain choices, i.e., choosing nursing as a career or hiring psychiatric mental health nurses.

3. Regional variations in population, educational expectations and opportunities.

4. The existence of a fragmented data base which makes market analysis difficult. Although there are national, regional, institutional and organizational data, they're not sufficiently comparable or retrievable to easily supply the information basic to national marketing effort.

5. It is unclear who should undertake these efforts. Is marketing of nursing and specialty areas the responsibility of our national organizations, non-nursing groups, governmental agencies, regional consortia or individual institutions?

6. Responsibility is compounded by the issue of who has the capability, interest, and resources to undertake all or part of the effort for psychiatric mental health nursing.

7. Mutual distrust among organizations, institutions, and non-nursing professions over who will benefit from such an undertaking.

Methodology

In order to fully implement the standard marketing strategies already utilized in a variety of enterprizes, there are a number of important steps to take, including establishing a data base, identifying the various publics and tailoring educational programs, expanding personal contact network, establishing follow-up efforts, and increasing organizational efforts.

If a successful set of strategies is to be utilized to create an interest in and demand for nursing and particular clinicians, a data base must be established which provides the appropriate information. Although there is a great deal of information about nursing and nurses from federal sources and professional organizations, these data are not made available in formats which incorporate the most useful statistics, nor are the data released by government, association, or institutional sources sufficiently comparable to form a broad data base. There is a great need to coordinate these sources and their construction of information, as well as to influence and promote data collection and analyses in a way that the data base will be broadened.

What publics must be targeted in this marketing and recruitment effort? The populations we must address include the general public, who are our pool of potential client-consumers; health care agencies, another pool of potential consumers of practitioners; future practitioners, from junior and senior high school students, baccalaureate graduates with degrees other than nursing, and prepared practitioners who may not have selected psychiatric mental health practice; guidance counselors and placement directors; and particularly nurse recruiters, who still espouse the idea that new graduates should have a year of medical-surgical nursing before going on to other practice choices. How these publics will be reached can be as varied as the publics themselves--some techniques can be used for more than one group and others will have to be modified to be meaningful to a particular group.

Probably one of the most successful elements in the marketing and recruitment effort is the use of our current active and inactive clinical specialists who speak enthusiastically and authoritatively about psychiatric mental health nursing practice, the need for more practitioners, and societal and patient requirements of the near future.

The organization of effort, expenditure of resources and, most importantly, the degree of need for psychiatric nurses, requires an organized, systematic follow-up of the success of these efforts population by population; this includes case analysis as well as practitioner and agency response.

To broaden the marketing and recruitment campaign, various organizational alliances present possibilities. Collaborative efforts between an agency and school(s) and between agencies and non-nursing organizations, consortia efforts uniting institutions characteristically similar although geographically distant, and coordinated efforts by nursing and non-nursing organizations, could sustain the marketing effort and reduce the resource investment of any one participant.

Summary

Marketing was defined as developing an interest in and creating a demand for a product. The history of the current situation was reviewed, the reasons for the need to begin a marketing effort at this time and the obstacles to its development were identified. Five components of the marketing methodology were discussed and where possible were compared to the survey findings presented in the initial portion of the conference.

MARKETING PROBLEMS AND STRATEGIES

Recommendations:

I. With respect to recruitment to nursing in general.

A consortium (or geographic consortia) of educational institutions should be created to develop, implement and share marketing strategies for recruitment into nursing.

II. With respect to recruitment into Psychiatric Mental Health Nursing.

1. A task force should be established to work with the Center for Manpower Research and Development (NIMH) to study the extent of and reasons for Psychiatric Mental Health nurse shortages and develop strategies for relieving these shortages.

2. A task force should be established to work with State and Federal Manpower Offices to outline Psychiatric Mental Health Nursing recruitment proposals and seek funding for their implementation.

3. Graduate programs in Psychiatric Mental Health Nursing must take a leadership role in recruitment through efforts and activities such as open houses and development of brochures; involvement of faculty as role models; inservice education to agencies; developing more flexible part-time programs and more work-scholarship programs with agencies; and involving agency personnel in curriculum planning and implementation.

III. Marketing Psychiatric Mental Health Nursing

Psychiatric Mental Health Nursing practice should be marketed to health care consumers, health care providers, legislators, and the general public.

SHORTAGE CONSEQUENCES IN THE SERVICE SETTING

Elizabeth Morrill, R.N., M.S.N.

This group is going to be addressing the highly publicized issue of a shortage of registered nurses in this nation. I would like to proceed by first defining the problem. It is necessary to stress the importance of defining the problem because if we go on the premise that there is a net shortage of RN's, the solutions are fairly simple. Either we find ways to produce more or we find other people to do the job. We are already seeing these approaches applied and I believe to the detriment of the health care delivery system.

After defining the problem, we will look at some of the history of nursing that has contributed to where we are today. That will bring us to look at various factors contributing to the problem.

Next, we will look at the solutions that were recommended by various studies as well as what is really being done. I will share some of the experiences in the State of Maryland with the solutions applied there. Hopefully, this will bring us to a better understanding of some problems that exist in relation to nursing today, or at least promote some discussion of the issues that I intend to raise.

The whole subject of shortage is, for many reasons, one that tends to inspire anti-nursing sentiments from many outside of the profession as well as to create heated conflicts within the profession. I am sure that when we get to a discussion that we will have strong disagreements as to the definition, the causes, and the solutions to the problem.

Before I get into how I am defining the problem, I think you need to know my background--I am an administrator. In the State of Maryland, there are approximately 5,800 personnel in psychiatric institutions, and of those, approximately 3,712 are direct care, 3,100 are nursing personnel, 200 are social workers, 200 are psychologists, 200 are physicians, and 800 are employed in community mental health centers. As of February, 1981 the inpatient census was 3,456. Total admissions for 1980 were 10,497. The budget appropriation for FY 1981 was $119,000,000.

The profession of nursing has been in the past, and to a great extent today, defined by the environment in which the nurse is employed, namely the hospital. It is from this vantage point, the hospital, that there is a perceived deficit. The issue of "nursing shortage" has been presented as a dilemma of the profession rather than a symptom--the greater undesirable hospital working conditions. It is this latter concern which I would like to address.

According to Dr. Linda Aiken (1981), assistant vice president of the Robert Wood Johnson Foundation, "The harsh reality is that many nurses simply do not want to work in today's hospitals. And many nurses who do remain are greatly dissatisfied. Some of the frustration is borne quietly and is reflected in high turnover rates."

According to Dr. Aiken, there are more than one million nurses practicing in the U.S., which is twice the number in 1960. This means that for every 200 Americans, there is one full-time practicing nurse today as compared with one nurse for every 335 people in 1962. During that same period of time, there has been no net increase in the nation's hospital bed capacity. This information is supported by most other studies that I have seen.

The Maryland Hospital Association (1980) published a report which defined the problem as a "hospital nurse shortage." Interestingly enough, the report ranked decline of nursing as a career choice as the number one cause of the hospital nurse shortage, and hospital policies as number eight. The number one solution proposed by the Association was to facilitate the production of more RN's through new hospital programs. It is difficult to see the logic in defining the problem as one that is unique to hospitals and not address those aspects of employment in hospitals that contribute to an inability to attract nurses. There is really no reason to believe that nurses trained in new hospital programs will be any more satisfied with these working conditions.

There is a direct correlation between the historical problems in nursing education and working conditions for nurses in hospitals today. The efforts to standardize nursing education brought extreme negative reactions from the AMA and the AHA, both of whom have wanted control over nursing.

By 1950, it was obvious that reform was necessary in both nursing education and in hospital settings. Since that time, some progress has been made. Hospitals no longer play a major role in the production of nurses. Academic settings have become the place for the education of professional nurses. Associate degree programs have also flourished. This variety leads to the obvious question concerning the issue of three different kinds of programs producing different levels of nurses. This fosters public misconceptions about nursing. The ANA has attempted to clarify this concern by making a policy statement about entry into practice. In 1965, the Association took the stand that the minimum preparation for beginning professional nurses should be baccalaureate education. This is a highly controversial issue and I do not intend to address the subject because it could well divert our attention from the problem at hand.

There have been an exhaustive number of studies that have addressed the issue of whether there is a shortage. At this point, I believe we need to move on to see why there is a shortage of nurses in hospitals. There are some potentially destructive events that may occur due to publicizing the issue too much. One is that nurses now working in hospitals may feel less guilty about leaving the hospital setting. Another is that the number of people who are potential candidates to enter the field might be discouraged from, doing so.

Obviously, I am defining the situation as a shortage of nurses willing to work in hospitals. If my assumption was that there is a net shortage, I would proceed towards the area of production of more nurses, but I would not advocate shorter and cheaper hospital programs. With the definition of the problem as stated, it is important to consider some aspects of the history of nursing that could lead to a misunderstanding of why the problem exists.

The early history of nursing is part of the reason that hospital costs are so high today. In earlier times, students or apprentice nurses staffed the hospitals without pay, which kept hospital costs artificially low. The student nurses who staffed the hospitals were required to work anywhere from 60 to 105 hours a week and attend meager classroom studies on their own time. Nurses were expected to pay for their own education by subjecting themselves to up to three years of labor in hospitals without remuneration (Ashley, 1976:30-31).

The existence of this pool of free labor made for serious employment problems for graduate nurses. Up until about 1950, unemployment was a serious problem for this group. A demand for additional nursing services could be met easily by the many hospitals with "Schools of Nursing" by increasing enrollment in the "school." Hospital administrators and officials preferred student nurses to graduates, not only because of the obvious economic advantages, but also because students were less independent than graduates. This contrast was dramatized at the 1913 meeting of the American Hospital Association when Mary Alberta Baker, a superintendent of nurses at a Florida hospital, set forth the argument that student nurses were far superior to graduates in providing hospital care--a major reason being that the more experienced graduates did not display "feelings of loyalty or devotion to the hospital, its traditions, methods or its doctors (American Hospital Association, 1913)." In the discussion which followed Baker's remarks, other members of the Association indicated their preference for student nurses because they were "loyal to the institution" and "anxious to please" physicians (Ashley, 1976:55-56).

In many instances, the "Schools of Nursing" or "training schools" operated by hospitals provided very little professional education for the overworked students. According to the survey, Nursing Schools Today and Tomorrow, published by the Committee on the Grading of Nursing Schools (1934), "In 1932, 23 percent of the schools did not even have one full-time instructor, and only 25 percent had two or more." According to the same report, in the mid-thirties, just under 30 percent of the salaried teaching staff had not even finished high school, and of those that had, more than half had no college education whatsoever. Only 20 percent of the total number of training school staff members in the country "had as much as one full year of college."

During this era, most physicians joined with hospital owners and administrators in their opposition to improvements in working conditions for student nurses. A dramatic exception to this was a

Virginia physician, W. A. Baker. In 1918, Baker wrote to Isabel Stewart, a staff member of the Division of Nursing Education at Teachers College in New York City, stating: "I wish to call your attention to an abuse that should be corrected; it is the long hours of service required of pupil nurses. We have societies that look after dogs, horses, birds, and fishes, yet so far I have not heard of any society or individual coming to the aid of pupil nurses (Baker, 1918)."

Baker submitted an article on this topic to the Journal of the American Medical Association, but the editor refused to publish it, maintaining that there were a great many nursing schools which "treated the pupils with every consideration (Ashley, 1976:39)." In 1919, Baker presented a paper to his county medical society called "A Flagrant Injustice" in which he attacked "profiteering" and the resulting "destruction of the health and future usefulness of young womanhood." His medical colleagues in the local society were sufficiently moved by Baker's plea to pass a resolution urging the Virginia legislature to enact laws prohibiting long hours of service by student nurses, but the appeal went unheeded (Ashley, 1976:39).

In 1920 the National League of Nursing Education began a different type of campaign to improve conditions without resort to legislation. Their efforts had some effect, for by 1923 several of the better schools in the country had achieved a 56-hour work week for students. This was only a small step forward, however, because the majority of schools still failed to "provide one day's rest in seven (Committee for the Study of Nursing Education, 1923)."

Nursing leaders began to take a look at the issues and realized that nursing was clearly not in control of their profession and that nursing education was consistently poor.

Hospital administrators and physicians began to create a means to produce a different kind of nurse whose fee would be less. Physicians were the strongest advocate for short courses for nurses. Most did not want nurses with spcialized knowledge. In 1919, J. D. Robertson, Commissioner of Health in the City of Chicago, opened a "nursing school" offering an 8-week course and apparently produced thousands of so-called nurses (Robertson, 1919). He believed that the products of his course were desirable because they were prepared and willing to do housework. Correspondence courses emerged. These various programs led to large increases in the number of nurses. A special study in New York state by Harlan Hoyt Horner (1934), Assistant Commissioner for Higher Education in the New York State Department of Education, showed an increase of 219 percent in the number of nurses registered in that state in the 11-year period 1922 to 1933.

All of these factors led to obvious problems that continue today. Nurses suffered low morale, lack of autonomy, a poor public image. The AMA and AHA consistently had organized opposition to reform in nursing. Obviously, these factors led to making nursing a fairly unattractive career. Thus, around 1940, we began to hear about the shortage of nurses.

Around that time, the NLN devised standards to apply to nursing education. In looking at programs, the NLN found extreme inconsistencies.

The various studies of the causes of the nursing shortage across the nation reveal almost identical data. A significant study by Wandelt (1980), which surveyed 3,500 nurses in Texas, found that nurses who leave nursing do so mainly because of the conditions of work. More specifically, these conditions involved quality of patient care, the professional role of the nurse, and job conditions under which they worked. A summary of studies that search for the causes of the problem in nursing today reveal fairly consistently the following: a reality shock that occurs when the graduate enters employment; rigid hospitals; understaffing in terms of FTE's by hospital administration, which results in a need for overtime for RN's; poor utilization of RN's in terms of the trend that movement upward in the career ladder requires an RN to go the administrative route, which takes her away from the patient; inappropriate staffing in terms of working shifts, which sometimes means a nurse works three different shifts in one week; the RN is devalued in hospital settings in many ways which leads to burnout; a lack of professional respect by physicians; inadequate educational preparation of the RN; inadequate compensation for the work; lack of autonomy; and adversary relationships between hospital managers and professional nurses.

The list goes on, and as you can see, the major concerns fall in two areas: conditions in hospitals and issues related to nursing education. There is no simple remedy. For example, an analysis by the Maryland Hospital Association (1980) indicated that simply raising salaries will not have a significant effect on the hospital's ability to attract and retain nurses. Nor will producing a new kind of nurse by creating diluted programs.

In taking a look at the solutions that are being applied to the problem, you will find a significant amount of disparity between the causes identified and the approaches taken. In the State of Maryland, as in many other states, the focus has been on recruitment and on producing more RN's in an "innovative program." Let me describe how these activities have evolved in Maryland.

First, the recruitment efforts were most obvious. In the beginning, apparently based on the assumption that the shift changes were the main cause of dissatisfaction in nursing, the temporary agencies began to compete with hospitals to recruit nurses. The campaign was successful to a degree, but then these agencies began to find that in many cases they were unable to produce RN's for the undesirable shifts.

The hospitals began strong recruitment efforts. These efforts included such strategies as offering a new car for an RN to work night shifts permanently; offering a full-time salary and benefits to RN's who were willing to work two 12-hour shifts over the weekend; offering a $1,000 bonus to be given to RN's who would accept employment; offering flex time; and more.

These efforts have not produced the results that were desired because the competition to recruit increased in intensity.

Another experience that we have had in Maryland has been aimed at producing more nurses by creating "innovative" means of producing RN's in a low cost program that is shorter than any of the existing types of programs. This was accomplished by having a hospital apply to the Maryland Cost Review Commission for an increased per diem charge for patients and that money was intended to pay for this new program. The program was aimed at turning LPN's into RN's. Any LPN who had six credits in some specified area and who had one year experience as an LPN qualified to enter the program. The one year of experience as an LPN is considered to be equal to a year of supervised clinical training towards RN status in the specialty areas in nursing (medical/surgical, pediatric, psychiatric, etc.). (To take this literally, an LPN who has worked in a methadone clinic for one year and has six credits would qualify for the program). The student would then take one year to obtain 30 credits and some limited clinical experience and would qualify to sit for the examination for licensure.

This dilution of a nursing program has far reaching effects that will most surely have an adverse effect on patient care at a time when patients in our hospitals are more acutely ill and nursing judgment based on a body of knowledge is vitally important.

There is another alternative especially viable in mental health nursing that we do not hear much about but exists and that is: breaking the theory of nursing care and the body of knowledge relevant to the nursing process into categories of tasks and teaching a task to a set of nonprofessionals, attempting to provide patient care in this manner. The obvious danger in this is that those people who have only tne technical skills required to perform a specific task have no knowledge of how to make judgments as to the appropriateness, the timing, the indications, and the contraindications. When the physician is not on the unit (which is most of the time) these are the people who will be depended on to exercise judgment that requires a knowledge base which they lack.

None of the approaches are really addressed to the conditions that are consistently described in our hospitals. If we do not pay attention to the total picture, no one solution will make the problem go away. It is my belief that nursing educators and nursing employers need to work together to look at the various aspects of the problem. It is also imperative that nursing should be able to articulate the difference between the products of the levels of entry into practice and articulate what a professional nurse is, especially in the face of seeing other levels emerge.

It seems that it is absolutely necessary for improved communication to occur between the hospital administrators, nursing administrators, and nursing educators. I believe that it is time to stop ruminating about whether there is a shortage and face the fact that nursing is not in control of its destiny and to work on the severe difficulties that are facing us.

I believe that this conference is a step in the right direction.

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SHORTAGE OF PSYCHIATRIC MENTAL HEALTH NURSES IN SERVICE SETTINGS

Recommendations:

I. Educators and Service Groups should establish communications.

   1. We urge the convening of multidisciplinary meetings to address recruitment and retention of psychiatric mental health nurses, and the constraints on their practice in service settings. Such meetings should include representatives from national and regional manpower development offices, SREB, WICHE, MAIN, ANA Division of Psychiatric Mental Health Nursing, NLN Council of Baccalaureate and Higher Degrees, Association of Mental Health Administrators, National Association of State Mental Health Program Directors, National Council of Directors of Psychiatric Mental Health Nursing Programs, The Joint Commission on Interprofessional Affairs, and the Council of Advanced Psychiatric Mental Health Nurses.

   2. State mental health commissioners, regional manpower officers and psychiatric nursing educators and administrators should meet regularly to discuss recruitment, curriculum, and service issues.

   3. Psychiatric nursing educators should meet regularly with local mental health program directors and psychiatric nursing service administrators to address recruitment, curriculum, and service concerns.

II. The ANA Division on Psychiatric Mental Health Nursing Practice, the National Council of Graduate Psychiatric Mental Health Nursing Program Directors, and Council of Advanced Psychiatric Mental Health Nurses should:

   1. Clarify differences in knowledge and skills of various levels of nurses working in psychiatric mental health settings (AD, BSN, MSN, Doctorate) and:

   2. Urge the development of competency-based education in the area of psychosocial rehabilitation skills.

III. Service settings should be responsive to current nursing demands in all clinical settings for:

   1. Competitive salaries which may be derived by more flexible regional salary structures.

   2. Improved working conditions and opportunities for professional psychiatric nursing practice.

3. Creative personnel policies, e.g., transferrable retirement programs, clinical career ladders, educational benefits.

4. Funding and opportunity at the state or regional level for clinical nursing research.

5. Funding for advanced psychiatric nursing education.

IV. Psychiatric Mental Health Nursing Service Administrators and Educators should collaborate in:

1. Developing model units to demonstrate higher quality nursing practice which incorporates the necessary education and research components.

2. Planning orientation and inservice education.

3. Establishing joint clinical/faculty appointment mechanisms.

4. Recruiting racial minorities and men into the field of Psychiatric Mental Health Nursing.

5. Informing service administrators of the value of psychiatric mental health nurses in acute and chronic mental illness settings so that they may be recruited and utilized in appropriate roles.

CLOSING REMARKS

Rhetaugh Dumas, R.N., Ph.D., F.A.A.N.

When this conference was planned, we, at NIMH, knew of the critical need to address in an organized forum effective ways to insure an adequate supply of well-prepared psychiatric-mental health nurses. We needed the input from those who educate psychiatric-mental health nurses and from those who utilize their services to instruct our planning at NIMH and to strengthen our efforts to justify the need for continuing Federal funding for psychiatric nursing education.

We did not know at the time this conference was planned that all NIMH clinical training programs (including psychiatric-mental health nursing education) would be scheduled for phaseout as part of the new Administration's Federal policy and budget initiatives.

We now all know that Federal proposals intended to reduce inflation and ease the troubled economy are casting a dim shadow on the future of Federal funding for psychiatric-mental health nursing programs. This comes at a time when there is a growing pervasive concern about the number of vacancies around the country for psychiatric-mental health nurses. And when there are other indications as well that the current supply and the rate of production are inadequate to meet current and anticipated demands for this category of mental health personnel.

Certainly, my colleagues and I at NIMH are greatly concerned about the future directions of mental health care and the impact of current budget and policy proposals on the goals of accessible and affordable mental health services for all who need them. We all share this goal and psychiatric-mental health nursing has made significant contributions to the progress that has been made so far.

In his opening remarks, Dr. Pardes reviewed the important landmarks and outstanding achievements in the mental health field. Indeed, the progress we have witnessed in mental health research, in mental health services, and in the education of research and services personnel, has changed the nature of the mental health field dramatically. And, NIMH support has had significant impact on the progress of psychiatric-mental health nursing as well.

Dr. Fagin, in her introductory remarks, referred to psychiatric nursing as having been considered "avant garde." I would certainly agree with that characterization. I have not formally surveyed the field, but in the 1960's and 1970's psychiatric nurses held some of the most impressive positions of leadership around the country. We were contributing to the professional literature in larger proportions than any other nursing specialty. We pioneered clinical nursing research, and we made important landmarks in the development of nursing theory.

We are at a critical juncture in this field of specialization where we are pressed to work harder and at a swifter pace to address the conditions of work, the status of the profession, the problem of insuring appropriate rewards and adequate renumeration for our services--and the need to insure progressive development of the field--through research, academic programs, and clinical service. We are at this juncture at a time when the major funding resources are under the threat of abolishment, and at a time when there is a "perceived decline" in the supply of psychiatric-mental health nurses.

This Conference has focused primarily on problems related to perceptions around the country that have led many to conclude that the supply of psychiatric nurses is declining. Discussion groups have enumerated factors thought to be influential and have offered specific recommendations for corrective action.

The discussions and debates have been stimulating and productive. But--I find myself in a position similar to that which my mother frequently assumed when I was growing up. I call it the "yes--but" position. It went something like this:

> "Yes, you have done a good job--and I am proud of you--But--you haven't done this or you must now do this."

And so my response to all that has transpired during this Conference goes something like the following:

> "Yes, we have made significant strides in the development of psychiatric-mental health nursing--and we can feel proud of our contributions in the mental health field--But--we have not prepared well for the day when we can no longer depend upon NIMH funding.
>
> "We must move fast to find alternatives for funding graduate education in psychiatric-mental health nursing.
>
> "We must provide more flexibility in the design of our training programs. Most, although not all, of our programs are structured for full-time study. We must provide options for part-time study.
>
> "We must consider contracting to receive funding for services provided in clinical agencies by students, and for faculty practice as well.
>
> "We must give greater attention to documenting (demonstrating) the impact of training programs on the quality of care in the agencies we utilize for student practicum. We should negotiate financial support in exchange for service.
>
> "We must monitor and participate in decisions that will affect this field.
>
> "We must engage actively in assisting States and local governments to plan for and provide for mental health care of people in these jurisdictions.
>
> "We will need to call upon States and localities to provide funding assistance for psychiatric-mental health nursing education.
>
> "We will need to consider ways to obtain funding assistance from the private sector.
>
> "Yes, during this Conference, we have identified some possible factors that might influence the choice of psychiatric nursing

as a career. This is an important first step for recruitment of larger numbers for the field.

"Yes, there are a number of vacancies for psychiatric-mental health nurses in some sections of the country.

"Yes, there appears to be a shortage in the supply of psychiatric-mental health nurses.

"But--this may not necessarily mean that the absolute number of psychiatric-mental health nurses in the country is declining. No statistics were presented that revealed fewer psychiatric nurses today than previously.

It is possible that areas in which psychiatric nurses practice have expanded at a faster pace than the rate of production.

"Yes, it is probably necessary to develop more effective ways to increase the supply.

"But--in the absence of an adequate data base for determining supply and demand, it is difficult if not impossible to speak with assurance about a shortage of psychiatric nurses. And, consequently, our strategies intended to relieve what we believe to be a shortage might be misdirected."

One of the groups here recommended that we move swiftly to develop a data base for assessing current supply, needs, and demands for projecting the future. I cannot overemphasize the need to develop and maintain a data base for those functions and for addressing critical issues having to do with the nature and impact of psychiatric nursing practice. The absence of this data base continues to constrain the field and it has constrained us at NIMH over the years as we endeavored to rationalize the clinical training budget.

Although the role of the Federal Government is shifting and NIMH clinical training programs are not among the priorities for the future, this does not mean that we are no longer concerned about the goals we have worked toward over the years.

Quite the contrary! We are still concerned about the need to provide professional mental health services of high quality to all who need them, particularly to those who have remained underserved or inappropriately served. We are still very much concerned that there is and will continue to be an adequate supply of personnel to provide services to the old, the young, to minorities, and the chronically mentally ill. Our interests have not changed. The mechanisms for achieving our goals and for addressing our mutual interests have changed.

There is little doubt in my mind that we are witnessing profound changes in policies and programs that have very significant implications for every aspect of the mental health field, and therefore, for our practice. There will be greater challenges in the mental health movement to help people to take better care of themselves. I think that the Federal Government will continue also to facilitate the movement toward prevention. These challenges require new commitment and even stronger determination to work on programs together at all levels of Federal, State, and local governments, and in collaboration with the private sector.

I am reminded of the opening lines from A Tale of Two Cities: "These are the best of times, these are the worst of times." I think if we look back on where we have come and the achievements that we have amassed in this field, we might just consider these the best of times. Certainly the 80's started out with great optimism. At this particular juncture, however, there is much uncertainty. I think that the uncertainty around future funding, resources, budgeting issues, and changes in Federal role, coupled with possible job losses, etc., signal for many the worst of times. Whatever final mandates we receive, we must work to protect the investments that have been made and to continue to work for the goals that we all share.

APPENDIX

RESOLUTION ON MENTAL HEALTH FUNDING*

WHEREAS many psychiatric mental health leaders have participated actively in the development of the Mental Health Systems Act and view it as a positive step in mental health care, and

WHEREAS these leaders believe that mental health services must remain viable and visible,

BE IT THEREFORE RESOLVED that this group urges support of the new Mental Health Systems Act and the funding necessary for its implementation.

Further, if the Mental Health Systems Act is vetoed and block grants are legislated as the support systems for federal funding, we urge the support of legislation for the development of a separate block grant for mental health.

---

*Adopted unanimously by the National Conference on Recruitment to Psychiatric Nursing on May 30, 1981.

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June 8, 1981

Dear Congress Member:

We urge your support of the enclosed resolution on funding for mental health services. The resolution was unanimously adopted on May 30, 1981 by the participants at the National Conference on Recruitment to Psychiatric Nursing.

We also urge your support of our recommendation that "NIMH should publicly recognize psychiatric mental health nursing as a critical shortage area and establish psychiatric nursing education as the highest priority for clinical training funds."

Because of our intense concern, the Planning Committee would appreciate a response from you regarding our request.

Sincerely,

Barbara J. Lowery, R.N., Ed.D., F.A.A.N.
Associate Professor of Nursing
Chair, Planning Committee

BJL/kr
Enclosures

RESOLUTION ON MENTAL HEALTH FUNDING SENT TO THE FOLLOWING MEMBERS OF THE U.S. CONGRESS

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